

<i>SERFF Tracking Number:</i>	<i>NWLC-125633999</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Nationwide Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>39003</i>
<i>Company Tracking Number:</i>	<i>COLLEGE POLICY 2008</i>		
<i>TOI:</i>	<i>H04 Health - Blanket Accident/Sickness</i>	<i>Sub-TOI:</i>	<i>H04.001 Student</i>
<i>Product Name:</i>	<i>Blanket Student Accident and Sickness Policy</i>		
<i>Project Name/Number:</i>	<i>2008 College Filing/</i>		

Filing at a Glance

Company: Nationwide Life Insurance Company

Product Name: Blanket Student Accident and Sickness Policy SERFF Tr Num: NWLC-125633999 State: ArkansasLH

Sickness Policy

TOI: H04 Health - Blanket Accident/Sickness

SERFF Status: Closed

State Tr Num: 39003

Sub-TOI: H04.001 Student

Co Tr Num: COLLEGE POLICY 2008

State Status: Approved-Closed

Filing Type: Form

Co Status:

Reviewer(s): Rosalind Minor

Authors: Bobby Handley, Jonna Shields, Shana Paladino-Ripp

Disposition Date: 05/16/2008

Date Submitted: 05/14/2008

Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: 2008 College Filing

Status of Filing in Domicile: Pending

Project Number:

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Group

Submission Type: New Submission

Group Market Size: Large

Overall Rate Impact:

Group Market Type: Blanket

Filing Status Changed: 05/16/2008

State Status Changed: 05/16/2008

Deemer Date:

Corresponding Filing Tracking Number:

Filing Description:

This is non-renewable group blanket accident and sickness insurance which is to be made available to graduate, professional, undergraduate, and international students who pay full registration fees and attend the public, state funded or private universities or colleges. As part of the registration process, these students are either automatically eligible for and enrolled in the insurance plan or may elect to coverage for themselves and dependents (this will depend on the requirements of each college/university). Dependent coverage may also be purchased under this policy if the

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college/university chooses it.

I have also included six riders - organ transplant, infertility, obesity treatment, sports accident, conversion, and transgender. These additional benefits can be purchased separately by the colleges/universities.

All benefits listed on the Schedule of Benefits pages are options that the Policyholder School can elect to fit their needs. This policy is similar in language to policies sold and marketed by Guarantee Trust Life Insurance Company, MEGA Life Insurance Company, and Aetna Life Insurance Company. Items contained within brackets, tables or which are underlined are filed as variable. An explanation of variables is included with this submission.

Each student at the colleges/universities will receive a brochure that gives a basic overview of the coverages chosen by their school. I am including a certificate of coverage/brochure for your review. Be advised that the actual brochure the students receive will not look like this certificate. However, the benefits will be the same. Each school's brochure will be unique based upon the insurance needs of each school. The actual policy that is issued will be available at the school.

Please note that the benefits payable between a PPO and Non-PPO will be no more than a 25% differential in payment.

Upon approval, this filing will replace the a previously approved filing (see SERFF # NWLC-125167978).

Your prompt attention to this submission will be appreciated. If there are any questions, please do not hesitate to contact me.

Company and Contact

Filing Contact Information

Bobby Handley, Assistant General Counsel handleb2@nationwide.com
5525 Parkcenter Circle (614) 854-3375 [Phone]
Dublin, OH 43017 (614) 854-3469[FAX]

Filing Company Information

Nationwide Life Insurance Company	CoCode: 66869	State of Domicile: Ohio
5525 Parkcenter Circle	Group Code: -99	Company Type:
Dublin, OH 43017	Group Name:	State ID Number:

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<i>Project Name/Number:</i>	<i>2008 College Filing/</i>		

(800) 525-8669 ext. 43508[Phone]

FEIN Number: 31-4156830

SERFF Tracking Number: NWLC-125633999 State: Arkansas
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TOI: H04 Health - Blanket Accident/Sickness Sub-TOI: H04.001 Student
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Filing Fees

Fee Required? Yes
Fee Amount: \$50.00
Retaliatory? Yes
Fee Explanation: Ohio charges \$50 per filing.
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Nationwide Life Insurance Company	\$50.00	05/14/2008	20323024

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	05/16/2008	05/16/2008

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Disposition

Disposition Date: 05/16/2008

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	EOV	Approved-Closed	Yes
Form	Policy	Approved-Closed	Yes
Form	Certificate/Brochure	Approved-Closed	Yes
Form	Enrollment Form	Approved-Closed	Yes
Form	Application	Approved-Closed	Yes
Form	Rider	Approved-Closed	Yes
Form	Rider	Approved-Closed	Yes
Form	Rider	Approved-Closed	Yes
Form	Rider	Approved-Closed	Yes
Form	Rider	Approved-Closed	Yes
Form	Rider	Approved-Closed	Yes
Form	Rider	Approved-Closed	Yes

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Form Schedule

Lead Form Number: NSHSAS 2000

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	NSHSAS 2000 AR	Policy/Cont ract/Fraternal Certificate	Policy	Initial		50	NSHSAS 2000 AR.pdf
Approved-Closed	NSHSAS 2500	Certificate	Certificate/Brochure	Initial		51	NSHSAS 2500 AR.pdf
Approved-Closed	NSHSAS 2800	Application/ Enrollment Form	Enrollment Form	Initial		0	NSHSAS 2800 - Student Enrollment Form.pdf
Approved-Closed	NSHSAS 2300	Application/ Enrollment Form	Application Enrollment Form	Initial		0	NSHSAS 2300 - School Application.pdf
Approved-Closed	NSHSAS 2400 Conversion	Certificate Amendment, Insert Page, Endorsement or Rider	Rider	Initial		49	NSHSAS 2400 Conversion.pdf
Approved-Closed	NSHSAS 2400 Infertility	Certificate Amendment, Insert Page, Endorsement or Rider	Rider	Initial		51	NSHSAS 2400 Infertility Rider.pdf
Approved-Closed	NSHSAS 2400 Obesity	Certificate Amendment, Insert Page, Endorsement	Rider	Initial		45	NSHSAS 2400 Obesity Rider.pdf

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 nt or Rider

Approved- Closed	NSHSAS 2400 Organ Transplan	Certificate Amendmen t, Insert Page, Endorseme nt or Rider	Rider	Initial	47	NSHSAS 2400 Organ Transplant Rider.pdf
Approved- Closed	NSHSAS 2400 Sports Accident	Certificate Amendmen t, Insert Page, Endorseme nt or Rider	Rider	Initial	46	NSHSAS 2400 Sports Accident Rider.pdf
Approved- Closed	NSHSAS 2400 Transgend er	Certificate Amendmen t, Insert Page, Endorseme nt or Rider	Rider	Initial	48	NSHSAS 2400 Transgender Rider.pdf



On Your Side®

Nationwide Life Insurance Company

Home Office: Columbus, Ohio

[UNDERGRADUATE] [GRADUATE] [INTERNATIONAL] BLANKET STUDENT ACCIDENT & SICKNESS POLICY

POLICY FACE PAGE

POLICY NUMBER: [000-000-000]

POLICYHOLDER: [ABC University]

ADDRESS: [1415 Murfreesboro Road
Nashville, Tennessee 37217]

EFFECTIVE DATE: [9/1/2003]

TERMINATION DATE: [9/1/2004]

Premium for each Insured person [SEE APPLICATION ATTACHED]

This Policy is issued to the Policyholder by Nationwide Life Insurance Company on the Effective Date at 12:01 a.m. standard time at Policyholder's address.

This Policy is governed by the laws of the State where it is issued and is a legal contract between the Company and Policyholder.

The Company hereby insures Eligible Persons, as defined by the Policyholder [and the Eligible Person's Dependents] for whom Premium has been timely paid. The Company agrees to pay Benefits set forth in this Policy. Benefit payment is governed by the terms, Conditions and limitations of this Policy.

READ YOUR POLICY CAREFULLY.

[This Policy is excess only. See the excess provision section of this Policy.] Benefits payable under this Policy are subject to reduction if a Covered Person is entitled to Benefits, whether on an indemnity basis or on a provision-of-service basis, for Hospital, medical, dental, or surgical expenses under any other valid and collectible individual, group, or blanket insurance Policy or contract, Hospital or medical service program, or group-practice prepayment plan, except for automobile medical payments insurance.]

**ONE YEAR NON-RENEWABLE TERM
BLANKET POLICY PROVIDING
SICKNESS AND INJURY COVERAGE
NON-PARTICIPATING**

RIGHTS AND RESPONSIBILITIES

Your responsibilities as a Covered Person include:

- Carrying Your Identification Card with You and presenting it prior to receiving health care services;
- Paying all Deductible, Coinsurance and Copayment amounts, if any, when due;
- Reading the Policy, knowing Your Coverage, and following the procedures outlined in the Policy to receive Maximum Benefits;
- Informing Us of any other health insurance You may have;
- Preventing the dishonest or false use of Your Identification Card by people not eligible for Coverage, and immediately reporting any such use to Us;
- Informing Us of any change in Your address or a Lifestyle Change which may alter Benefits for You or Your Dependents.

Your rights as a Covered Person include:

- Simple information and explanations from Your health plan to help You understand what is covered and what is not covered;
- A current list of Doctors, Health Care Practitioner, and facilities;
- Emergency care at any Hospital for a Condition You believe threatens Your life or seriously affects Your health;
- Information about steps You can take if You think Your health insurance plan has denied You Coverage of a treatment You believe is covered.

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SCHEDULE OF BENEFITS	
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[Your Coverage provides for the utilization of Network Providers in a Preferred Provider Organization (PPO). Certain Benefits are paid at different rates if the service is not provided by a Network Provider. See the Definitions page for the definition of Preferred Provider Organization, Network Provider, Non-Network Provider, In-Network Benefit and Out-of Network Benefit.]

[The Preferred Provider Organization(s) for Your Coverage [is –are]: _____].

[The Review Organization is: []]

[The telephone number of the Review Organization is on Your Identification Card.]

[Student Health Center (SHC) is not available to [Dependents,] [Dependent children,] unless specifically stated.]

[Explanation of Reference Number

¹ [Must be Pre-Certified] [Must be Pre-Notified]]

SCHEDULE OF BENEFITS

[Lifetime Aggregate Maximum*	[10,000-1,000,000]
[Student:]	[10,000-1,000,000]
[Dependent:]	[10,000-1,000,000]

[Including Repatriation and Medical Evacuation]

[Except treatment of an Injury resulting from a motor vehicle accident]	[5,000, 50,000-100,000]
--	-------------------------

[BASIC MEDICAL expense BENEFIT*]

Deductible, Per Sickness or Injury	\$[50, 75, 100]
------------------------------------	-----------------

[The Deductible shall not apply:

- To covered x-ray services performed at the Student Health Center;
- When referred to one of the foregoing facilities by the Policyholder's Student Health Center;
- To covered Outpatient Physiotherapy rendered for treatment of Sickness at the Policyholder's Physical Therapy Health Clinic; or
- Outpatient Prescription Drugs when prescribed and filled at the Policyholder's Student Health Center]

Insured Percent	80% up to \$[2,000 - 5,000] then 100% up to the Major Medical Aggregate Maximum Amount
------------------------	--

Basic Aggregate Maximum Amount Per Sickness or Injury	\$[25,000 to \$250,000]
--	-------------------------

Attention: If an Injury or Sickness first occurs during a Policy Year in which You select the Basic Medical Benefit plan, Covered Charges related to that Injury or Sickness will be limited to the maximum lifetime benefit amount set forth in the Basic Medical Benefit plan. This limitation will continue to apply even if You select the Enhanced Medical Benefit plan in subsequent Policy Years.

[ENHANCED MEDICAL expense BENEFIT*]

Deductible, Per Sickness or Injury	\$[50, 75, 100]
------------------------------------	-----------------

[The Deductible shall not apply:

- To covered x-ray services performed at the Policyholder's Student Health service;
- When referred to one of the foregoing facilities by the Policyholder's Student Health Center;
- To covered Outpatient Physiotherapy rendered for treatment of Sickness at the Policyholder's Physical Therapy Health Clinic; or
- Outpatient Prescription Drugs when prescribed and filled at the Policyholder's Student Health Center]

Insured Percent	80% up to \$[2,000-5,000] then 100% up to the Enhanced Major Medical Aggregate Maximum Amount
------------------------	---

Enhanced medical Aggregate Maximum Amount Per Sickness or Injury	\$[250,000 to 1,000,000]
---	--------------------------

[The Basic and Enhanced Medical Benefit plans do not cover [Mental Disorders], [Outpatient Prescription Drugs prescribed for Sickness] or [Outpatient physical therapy for a Sickness] in excess of the Basic Medical Benefit plan maximum.]

Policy Year Maximum Benefit *

[Student]	[\$250,000, 300,000] [per Injury or Sickness]
[Dependent]	[\$100,000, 300,000] [per Injury or Sickness]

Per Condition Maximum Benefit *

[Student]	[\$25,000,50,000,100,000,200,000,250,000]
[Dependent]	[\$25,000,50,000,100,000,200,000,250,000]

[Except treatment of an Injury resulting from a motor vehicle accident] [5,000, 50,000-100,000]

[including Repatriation and Medical Evacuation]

Pre-Notification Penalty	[0, \$250, \$500, \$750]] [paid at the Out-of-Network Benefit Level]
Pre-Certifications Penalty	[0-100]% of the applicable Network Benefit Level]
[Pre-Certification Penalty]	[paid at the Out-of-Network Benefit Level] payment is reduced by [\$500, 750, 1000] of the covered expense.] [paid at the Out-of-Network Benefit Level]

[If the Policy is excess, we will pay [an initial amount of [\$50, 100]] [for charges incurred [at the SHC][at the UCSF Medical Group]] for an Injury or Sickness and then we are secondary[, except Health Maintenance Organization (HMO) plans][, except for MediCal.]

[Out-of-Network claim payment] - The methodology for calculating Reasonable and Customary is based upon the [50th, 60th, 70th, 80th 90th] percentile of Ingenix and the prevailing rate in the community based upon zip code.

[* Combined [Student Health Center,] In-Network and Out-of-Network Benefit Levels]

Covered Services	[SHC]	In-Network Benefit Level	Out-of-Network Benefit Level
[Copayment][per office visit] [after first visit] [waived at the SHC]	\$[0-50]	\$[0-50]	\$[0-50]
[Copayments do not apply to Deductibles]			[Not applicable]]
[Copayments [including Prescription Copayments] do [not] apply to the Coinsurance Maximum Limit			
[Deductible,] [per Policy Year], [per Injury/] [Sickness] [Condition]	\$[0-1000]	\$[0-1000]	\$[0-1000]
[waived at the SHC]			
[waived in the case of an Emergency]			

[A new Deductible will apply each Policy Year. However, Covered Charges incurred during the last 3 months of a Policy Year which are applied to that Covered Person's Policy Year Deductible will also be applied toward that person's Deductible for the next Policy Year and thus reduce that Policy Year's Deductible.]

[Benefits are subject to Deductibles unless otherwise indicated.]

[The Deductible is waived for the Insured Student if the Insured Student first utilizes and/or is referred by the approved university Student Health Center or if the university Student Health Center is closed.]

expenses Incurred to meet the Deductible are cross applied [SHC], In-Network-Benefit and Out-of-Network Benefit.]

[The Deductible can be met by Student and [Family] [Dependent] expenses.]		[\$0] [N/A]	[\$50-2500]	[\$50-2500]
1.	[Single] [Student][Covered Person] Coverage			
2.	[Family] [Dependent] Coverage	[\$0] [N/A]	[\$50-2500]	[\$50-2500]
[Coinsurance Percentage] [except as specified herein]		[0-100%]	[0-100%][of Preferred Allowance]	[40-100%][of Reasonable and Customary expenses (R&C)]
[Coinsurance Maximum Limit, per Policy Year]		[\$500 to\$5000]	[\$500 to\$5000]	[\$500 to\$5000]
[Any Coinsurance paid by You is applied to the Coinsurance Maximum Limit per Policy Year]				
[Any Coinsurance paid by [Student and [Family] [Dependent] is applied to the Coinsurance Maximum Limit per Policy Year]				
[Once the Coinsurance Maximum Limit is reached by the Covered Person, the Coinsurance Percentage paid by the Company will be 100% In-Network and Out-of-Network.]				
1.	[Single] [Student][Covered Person] Coverage	[\$500 to\$5000]	[\$500 to \$6000]	[\$500 to 6000]
2.	[Family] [Dependent] Coverage	[\$500 to\$5000]	[\$500 to \$6000]	[\$500 to \$6000]

[PLEASE NOTE: ALL BENEFITS ARE PER POLICY YEAR UNLESS OTHERWISE NOTED.]

Covered Services	[SHC]	In-Network Benefit Level	Out-of- Network Benefit Level
Wellness Services (See Covered Services for more details)			
1. [Well Baby and child Care Age [0-18] and under]	[0-100% Coinsurance]	[0-100% Coinsurance]	[40-100% Coinsurance]
(Recommended immunization services covered at 100%)	[+ wavier of Deductible]	[+ waiver of Deductible]	[+ waiver of Deductible]
	[after Copayment]]	[after Copayment]	[after Copayment]
	[not covered at SHC]		[not covered Out-of-Network]
2. [Well Adult Care age [7, 17] and over Maximum payment not to exceed[\$100,\$250, 500] per Policy year]	[0-100% Coinsurance]	[0-100% Coinsurance]	[40-100% Coinsurance]
	[after Copayment]	[after Copayment]	[after Copayment]
	[+ waiver of Deductible]	[+ waiver of Deductible]	[+ waiver of Deductible]
	[Adult Dependent may use the SHC for adult wellness]	[Not covered outside the SHC]	[Not covered outside the SHC]
	[Annual physical is available for Student [and adult Dependent] at SHC only]		
a. [Coverage is limited to state mandate]	[0-100% Coinsurance]	[0-100% Coinsurance]	[40-100% Coinsurance]
	[after Copayment]	[after Copayment]	[after Copayment]
	[+ waiver of Deductible]	[+ waiver of Deductible]	[+ waiver of Deductible]
	[Adult Dependent may use the SHC for adult wellness]	[Not covered outside the SHC]	[Not covered outside the SHC]
	[Annual physical is available for Student [and adult Dependent] at SHC only]		

Covered Services	[SHC]	In-Network Benefit Level	Out-of- Network Benefit Level
b. [One (1) annual physical] or [PPD TB Test]	[0-100% Coinsurance] [after Copayment] [+ waiver of Deductible] [Adult Dependent may use the SHC for adult wellness] [Annual physical is available for Student [and adult Dependent] at SHC only]	[0-100% Coinsurance] [after Copayment] [+ waiver of Deductible] [Not covered outside the SHC]	[40-100% Coinsurance] [after Copayment] [+ waiver of Deductible] [Not covered outside the SHC]
3. [Adult Immunization[--Student Only]	[100% Coinsurance] [after Copayment] [after the Deductible] [+ waiver of Deductible] [[%] Coinsurance applied to all or select immunizations]	[% Coinsurance] [after Copayment] [+ waiver of Deductible] [not covered outside the SHC]	[%] Coinsurance [after Copayment] [+ waiver of Deductible] [not covered outside the SHC]
Includes <ul style="list-style-type: none"> • [Tetanus], • [Measles-Mumps-Rubella], • [Travel inoculations] • [Hepatitis A] • [Hepatitis B][paid at 50%] • [HPV] • [Flu] • [Pneumonia] • [Varicella] • [Meningococcal] • [Twinrix (combo Hepatitis A and B)] 			
[up to a \$[100-500] Lifetime Aggregate Maximum]	[Adult Dependent may obtain immunizations at SHC]		

Covered Services	[SHC]	In-Network Benefit Level	Out-of- Network Benefit Level
Outpatient Services - (other than Maternity, Mental Health/Drug or Alcohol)			
1. [Doctor office visits]	[Copayment]	[Copayment]	[Copayment]
a. [Evaluation and Management]	[% Coinsurance]	[% Coinsurance]	[% Coinsurance]
	[after Copayment]	[after Copayment]	[after Copayment]
	[+ waiver of Deductible]	[+ waiver of Deductible]	[+ waiver of Deductible]
b. [Diagnostic services performed and billed by a Doctor's office]	[Copayment]	[Copayment]	[Copayment]
	[% Coinsurance]	[% Coinsurance]	[% Coinsurance]
	[after Copayment]	[after Copayment]	[after Copayment]
	[+ waiver of Deductible]	[+ waiver of Deductible]	[+ waiver of Deductible]
2. [Outpatient Health Care Facility fees including, related Doctor services]	[Copayment]	[Copayment]	[Copayment]
	[% Coinsurance]	[% Coinsurance]	[% Coinsurance]
	[after Copayment]	[after Copayment]	[after Copayment]
	[+ waiver of Deductible]	[+ waiver of Deductible]	[+ waiver of Deductible]
		[If an In-Network facility is utilized, Out-of-Network Provider claims will be processed at the In-Network benefit level once R&C is established.]	

Covered Services		[SHC]	In-Network Benefit Level	Out-of- Network Benefit Level
Outpatient Services (other than Maternity, Mental Health/Substance Abuse)				
3.	[Diagnostic Imaging and Laboratory Procedures], [up to a \$[500-1,500] maximum per Condition]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible] [If an In-Network facility is utilized, Out-of-Network Provider claims will be processed at the In-Network benefit level once R&C is established.]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]
4.	[CAT Scan, MRI, and /or PET Scans] ^[1] [Maximum We will pay combined is [\$500, 700, 1000, 2000] per Injury/Sickness/Condition per Covered Person]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible] [If an In-Network facility is utilized, Out-of-Network Provider claims will be processed at the In-Network benefit level once R&C is established.]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]
5.	[Infusions and/or Injections done in an Outpatient Health Care Facility or Doctor's office] ^[1]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible] [If an In-Network facility is utilized, Out-of-Network Provider claims will be processed at the In-Network benefit level once R&C is established.]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]

Covered Services	[SHC]	In-Network Benefit Level	Out-of-Network Benefit Level
Outpatient Services:			
6. [Miscellaneous Outpatient Services]			
a. [including Radiation and Chemotherapy]	[Copayment]	[Copayment]	[Copayment]
	[% Coinsurance]	[% Coinsurance]	[% Coinsurance]
	[after Copayment]	[after Copayment]	[after Copayment]
	[+ waiver of Deductible]	[+ waiver of Deductible]	[+ waiver of Deductible]
		[If an In-Network facility is utilized, Out-of-Network Provider claims will be processed at the In-Network benefit level once R&C is established.]	
b. [Dialysis and Filtration Procedures]	[Copayment]	[Copayment]	[Copayment]
	[% Coinsurance]	[% Coinsurance]	[% Coinsurance]
	[after Copayment]	[after Copayment]	[after Copayment]
	[+ waiver of Deductible]	[+ waiver of Deductible]	[+ waiver of Deductible]
		[If an In-Network facility is utilized, Out-of-Network Provider claims will be processed at the In-Network benefit level once R&C is established.]	
Inpatient Services ^[1]			
1. [Hospital Services]	[Not Applicable]	[Copayment]	[Copayment]
		[% Coinsurance]	[% Coinsurance]
		[after Copayment]	[after Copayment]
		[+ waiver of Deductible]	[+ waiver of Deductible]
		[If an In-Network facility is utilized, Out-of-Network Provider claims will be processed at the In-Network benefit level once R&C is established.]	
[Miscellaneous Hospital expenses limited to \$[500-2,000] for the first day of Hospitalization and \$[500-2,000] per day each day thereafter]			

Covered Services	[SHC]	In-Network Benefit Level	Out-of-Network Benefit Level
a. [Room and Board expense, daily semi-private room rate and general nursing care provided by the Hospital.]	[Not Applicable]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]
b. [Intensive Care Room]	[Not Applicable]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]
c. [Consulting physician] [Up to \$[1,000-2500] maximum] [Doctor visits are limited to one visit per day [includes Consulting Physician]] [does not apply when related to surgery]	[Not Applicable]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]
d. [Pharmaceuticals administered while an Inpatient]	[Not Applicable]	[50-100]% of R&C	[50-100]% of R&C
e. [Skilled Nursing and Sub-Acute Care] [Maximum of [30-120] days], [per Injury] [per Sickness] [per Policy Year], [per Covered Person]]	[Not Applicable]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible] [If an In-Network facility is utilized, Out-of-Network Provider claims will be processed at the In-Network benefit level once R&C is established.]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]

Covered Services		[SHC]	In-Network Benefit Level	Out-of-Network Benefit Level
2.	[Inpatient rehabilitation]	[Not Applicable]	[Copayment]	[Copayment]
	[Maximum of [30-60] days], [per Injury] [per Sickness] [per Policy Year], [per Covered Person]]		[% Coinsurance]	[% Coinsurance]
			[after Copayment]	[after Copayment]
	[The maximum We will pay for Out-of-Network Inpatient rehabilitation charges is \$[500-2,000] per day, per Covered Person.]		[+ waiver of Deductible]	[+ waiver of Deductible]
			[If an In-Network facility is utilized, Out-of-Network Provider claims will be processed at the In-Network benefit level once R&C is established.]	[Not Applicable]
			[Not Applicable]	
Surgical Services ^[1]				
	[up to a \$[1,000-5,000] maximum]	[%] Coinsurance]	[%] Coinsurance]	[%] Coinsurance]
		[%] Coinsurance after Copayment]	[%] Coinsurance after Copayment]	[%] Coinsurance after Copayment]
			[If an In-Network facility is utilized, Out-of-Network Provider claims will be processed at the In-Network benefit level once R&C is established.]	
1.	[Surgeon]	[%] Coinsurance]	[%] Coinsurance]	[%] Coinsurance]
	[up to a \$[1,000-5,000] maximum]	[%] Coinsurance after Copayment]	[%] Coinsurance after Copayment]	[%] Coinsurance after Copayment]
			[If an In-Network facility is utilized, Out-of-Network Provider claims will be processed at the In-Network benefit level once R&C is established.]	

Covered Services	[SHC]	In-Network Benefit Level	Out-of- Network Benefit Level
2. [Assistant Surgeon]	[%] Coinsurance	[%] Coinsurance]	[%] Coinsurance]
	[%] Coinsurance after Copayment]	[%] Coinsurance after Copayment]	[%] Coinsurance after Copayment]
		[Up to [20- 25]% of Surgeon fees]	
		[If an In-Network facility is utilized, Out-of-Network Provider claims will be processed at the In-Network benefit level once R&C is established.]	[Up to [20- 25]% of Surgeon fees]
3. Anesthesia Services	[%] Coinsurance]	[%] Coinsurance]	[%] Coinsurance]
[up to a \$[1,000-5,000 maximum]	[%] Coinsurance after Copayment]	[%] Coinsurance after Copayment]	[%] Coinsurance after Copayment]
[Out-of-Network Anesthesia charges will be paid at the In-Network Benefit level if an In- Network facility and Surgeon is used,]		[[80-100]% of R&C] [Up to [20-25]% of Surgeon fees]	
		[If an In-Network facility is utilized, Out-of-Network Provider claims will be processed at the In-Network benefit level once R&C is established.]	[[80-100]% of R&C] [Up to [20- 25]% of Surgeon fees]
4. [General Anesthesia for Dental services (See Covered Services for details)]	[%] Coinsurance]	[%] Coinsurance]	[%] Coinsurance]
	[%] Coinsurance after Copayment]	[%] Coinsurance after Copayment]	[%] Coinsurance after Copayment]
		[If an In-Network facility is utilized, Out-of-Network Provider claims will be processed at the In-Network benefit level once R&C is established.]	

Covered Services	[SHC]	In-Network Benefit Level	Out-of- Network Benefit Level
5. [Outpatient Hospital/Health Care/Surgical Facility fee] [up to a \$[1,000-5,000] maximum]	[%] Coinsurance [%] Coinsurance after Copayment]	[%] Coinsurance [%] Coinsurance after Copayment] [If an In-Network facility is utilized, Out-of-Network Provider claims will be processed at the In-Network benefit level once R&C is established.]	[%] Coinsurance [%] Coinsurance after Copayment] [50-75%] Coinsurance
6. [Office Surgery performed in a Doctor's office]	[%] Coinsurance [%] Coinsurance after Copayment]	[%] Coinsurance [%] Coinsurance after Copayment]	[%] Coinsurance [%] Coinsurance after Copayment]
7. [Inpatient Hospital Facility Fee]	[%] Coinsurance [%] Coinsurance after Copayment]	[%] Coinsurance [%] Coinsurance after Copayment]	[%] Coinsurance [%] Coinsurance after Copayment]
8. [Oral Surgery for Accidental Injuries]	[%] Coinsurance [%] Coinsurance after Copayment]	[%] Coinsurance [%] Coinsurance after Copayment] [If an In-Network facility is utilized, Out-of-Network Provider claims will be processed at the In-Network benefit level once R&C is established.]	[%] Coinsurance [%] Coinsurance after Copayment]

Covered Services	[SHC]	In-Network Benefit Level	Out-of- Network Benefit Level
9. [Reconstructive Surgery] ^[1]	[%] Coinsurance [%] Coinsurance after Copayment]	[%] Coinsurance] [%] Coinsurance after Copayment] [If an In-Network facility is utilized, Out-of-Network Provider claims will be processed at the In-Network benefit level once R&C is established.]	[%] Coinsurance] [%] Coinsurance after Copayment]

[No more than one surgical procedure will be covered when multiple procedures are preformed through the same incision or in immediate succession]

[When Injury or Sickness requires multiple Surgical Procedures through the same incision, We will pay an amount not less than that for the most expensive procedure being performed. Multiple Surgical Procedures performed during the same operative session but through different incisions shall be reimbursed in an amount not less than the Covered Percentage of the Covered Charge of the most expensive Surgical Procedure then being performed, and with regard to the less expensive Surgical Procedure in an amount equal to 50% of the Covered Percentage of the Covered Charge for these procedures.] [\$[2,500-10,000]] allowed per surgical event]

Covered Services	[SHC]	In-Network Benefit Level	Out-of-Network Benefit Level
Reproductive Services			
1. [Maternity Care] ^[1]			
1. [Pre- and Post-Natal Care, including delivery and In-Hospital Doctor visits for mother and baby]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]
2. [Hospital services] ^[1]			
	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible] [If an In-Network facility is utilized, Out-of-Network Provider claims will be processed at the In-Network benefit level once R&C is established.]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]
c. [Diagnostic services performed and billed by a Doctor's office, including ultrasounds and amniocentesis] [(the 1 st ultrasound is 100%; subsequent ultrasounds are subject to Deductible & Coinsurance)]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]

Covered Services	[SHC]	In-Network Benefit Level	Out-of-Network Benefit Level
3. [Voluntary Sterilization Surgery]			
a. [Performed in a Doctor's office]	[Copayment]	[Copayment]	[Copayment]
	[% Coinsurance]	[% Coinsurance]	[% Coinsurance]
	[after Copayment]	[after Copayment]	[after Copayment]
	[+ waiver of Deductible]	[+ waiver of Deductible]	[+ waiver of Deductible]
b. [Performed in an Outpatient Hospital]	[Copayment]	[Copayment]	[Copayment]
	[% Coinsurance]	[% Coinsurance]	[% Coinsurance]
	[after Copayment]	[after Copayment]	[after Copayment]
	[+ waiver of Deductible]	[+ waiver of Deductible]	[+ waiver of Deductible]
		[If an In-Network facility is utilized, Out- of-Network Provider claims will be processed at the In- Network benefit level once R&C is established.]	
c. [Elective termination of pregnancy]	[Copayment]	[Copayment]	[Copayment]
[up to a \$[100-1,000] maximum]	[% Coinsurance]	[% Coinsurance]	[% Coinsurance]
	[after Copayment]	[after Copayment]	[after Copayment]
	[+ waiver of Deductible]	[+ waiver of Deductible]	[+ waiver of Deductible]

Covered Services	[SHC]	In-Network Benefit Level	Out-of-Network Benefit Level
Mental Disorder[([not]including Severe Mental Illness and Serious Emotional Disturbance of a Child)][and Alcoholism/Drug Abuse]			
a. Outpatient Office Visits ^[1] – [10,15, 20,30,40,50] visits ,[per Injury] [per Sickness] [per Policy Year], [per Covered Person]]	[Copayment] [% Coinsurance]	[Copayment] [50-100% Coinsurance]	[Copayment] [40-100% Coinsurance]
[up to a \$[500-2,500] maximum] [up to a \$[50-250] maximum per visit] [limited to one visit per [day][week]]	[after Copayment] [+ waiver of Deductible]	[after Copayment] [+ waiver of Deductible]	[after Copayment] [+ waiver of Deductible]
[for Dependents, up to a \$[500-2,500] maximum per Policy Year]			
b. Inpatient services ^[1] - [15, 20,25,30,40,50]days,[per Injury] [per Sickness] [per Policy Year], [per Covered Person]]	[Copayment] [% Coinsurance]	[Copayment] [% Coinsurance]	[Copayment] [% Coinsurance]
[up to a \$[500-2,500] maximum] [Doctor visits limited to \$[500-2,500], after Copayment]	[after Copayment] [+ waiver of Deductible]	[after Copayment] [+ waiver of Deductible]	[after Copayment] [+ waiver of Deductible]
		[up to 10 continuous days and 50% thereafter up to 35 additional days (100% if certified by Review Organization)]	[up to 10 continuous days and 50% thereafter up to 35 additional days (100% if certified by Review Organization)]

Covered Services	[SHC]	In-Network Benefit Level	Out-of-Network Benefit Level
[Alcoholism/Drug Abuse][Drug Abuse [(including Severe Mental Illness and Serious Emotional Disturbance of a Child)]			
a. Outpatient Office Visits ^[1] – [20,30,40,50] visits ,[per Injury] [per Sickness] [per Policy Year], [per Covered Person]]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]
b. Inpatient services ^[1] - [10, 20,30,40,50]days,[per Injury] [per Sickness] [per Policy Year], [per Covered Person]]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]	Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]	Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]
[Alcoholism]^[1]			
a. [Inpatient Alcoholism services – Limit of \$[500-2,500],[per Injury] [per Sickness] [per Policy Year], [per Covered Person]]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]
b. [Outpatient Alcoholism services – [20,30,40,50] visits ,[per Injury] [per Sickness] [per Policy Year], [per Covered Person]]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]

Covered Services	[SHC]	In-Network Benefit Level	Out-of-Network Benefit Level
[Urgent Care services] Copayment waived if referred to Emergency room or admitted to Hospital within [48,72] hours]	[Copayment]	[Copayment]	[Copayment]
	[% Coinsurance]	[% Coinsurance]	[% Coinsurance]
	[after Copayment]	[after Copayment]	[after Copayment]
[Note: The [Copayment] [Deductible]] amount, if any, for this visit is waived if You are referred to an Emergency room or admitted to a Hospital for the same Condition within [forty-eight (48), seventy-two (72)] hours of the visit.]	[+ waiver of Deductible]	[+ waiver of Deductible]	[+ waiver of Deductible]
[Follow up care at the Emergency room]	[Not covered]	[Not covered]	[Not covered]
[Emergency services] [[Copayment][ER Deductible] waived if admitted to Hospital [within [48,72] hours]] [or if Condition is life-threatening or would cause the Loss, or Loss of use, of a body part or organ] [or for treatment of a sexual assault] [includes after-hours charges] [Policy Year Deductible waived in the case of an Emergency] [for Injury, treatment must be within [forty-eight (48), seventy-two (72)] hours of Accident]	[Copayment]	[Copayment]	[Copayment]
	[% Coinsurance]	[% Coinsurance]	[% Coinsurance]
	[after Copayment]	[after Copayment]	[after Copayment]
	[+ waiver of Deductible]	[+ waiver of Deductible]	[+ waiver of Deductible]
	[+ waiver of Deductible]	[after \$[50-100] ER Deductible]	[after \$[50-100] ER Deductible]
		[[80-100]% when immediately followed by admittance or, after a \$[50-100] Deductible, [[50-80]% when not immediately followed by admittance]	[90% in the case of life-threatening Emergency]
		[Emergency care services are covered at [80-100%] for Emergency treatment received with in a [25-50]-mile radius of Student Health, when Student Health is closed, if immediately followed by admittance to Hospital for Inpatient treatment).]	[[50-80]% in the case of an Emergency, if outside a [25-50]-mile radius of the Student Health Center]
		[If an In-Network facility is utilized, Out-of-Network Provider claims will be processed at the In-Network benefit level once R&C is established.]	[Emergency care services are covered at [80-100%] for Emergency treatment received with in a [25-50]-mile radius of Student Health, when Student Health is closed, if immediately followed by admittance to Hospital for Inpatient treatment).]

Covered Services	[SHC]	In-Network Benefit Level	Out-of-Network Benefit Level
Emergency care Doctor		[50-100]% of R&C	[50-100]% of R&C
		[If an In-Network facility is utilized, Out-of-Network Provider claims will be processed at the In-Network benefit level once R&C is established.]	
[Follow up care at the Emergency room]	[Not covered]	[Not covered]	[Not covered]
Other Services			
1. [Allergy services]			
a. [Allergy Testing – [[1-3]series of tests,] [per Sickness] [per Policy Year], [per Covered Person]]	[Copayment]	[Copayment]	[Copayment]
	[% Coinsurance]	[% Coinsurance]	[% Coinsurance]
	[after Copayment]	[after Copayment]	[after Copayment]
	[+ waiver of Deductible]	[+ waiver of Deductible]	[+ waiver of Deductible]
		[Not covered outside SHC]	[Not covered outside SHC]
b. [Allergy Injections][Allergy treatment]	[Copayment]	[Copayment]	[Copayment]
[includes the following: treatment of anaphylaxis and angioedema, severe chronic sinusitis not responsive to medications and asthma not responding to usual treatments]	[% Coinsurance]	[% Coinsurance]	[% Coinsurance]
	[after Copayment]	[after Copayment]	[after Copayment]
	[+ waiver of Deductible]	[+ waiver of Deductible]	[+ waiver of Deductible]
	[+ waiver of Deductible]	[Not covered outside SHC]	[Not covered outside SHC]

Covered Services	[SHC]	In-Network Benefit Level	Out-of-Network Benefit Level
2. [Rehabilitative Care] -			
a. [Physical Therapy] ^[1]			
[Maximum Benefit \$[Copayment] per visit;]	[Copayment]	[Copayment]	[Copayment]
[\$500-2,000] [combined] [each] [PT] [OT]	[%	[% Coinsurance]	[% Coinsurance]
[ST]] [per Condition][per Policy Year]	Coinsurance]	[after Copayment]	[after Copayment]
	[after		
	Copayment]	[+ waiver of Deductible]	[+ waiver of
			Deductible]
	[+ waiver of		
	Deductible]		
[Maximum of [5, 10, 15, 20, 25, 30] visits [per			
Injury] [per Sickness] [per Policy Year], [per			
Covered Person]]			
[Copayment waived for first visit]			
[includes chiropractic care and acupuncture]			
[only for a Condition that required surgery or			
Hospital Confinement]			
[except for treatment received at the SHC]			
[limited to one visit per day]			
b. [Speech Therapy] ^[1]	[Copayment]	[Copayment]	[Copayment]
[Maximum Benefit [\$500-2,000]	[%	[% Coinsurance]	[% Coinsurance]
[combined] [each] [PT] [OT] [ST]]	Coinsurance]	[after Copayment]	[after Copayment]
[Maximum of [5-30] visits [per Injury] [per	[after		
Sickness] [per Policy Year], [per Covered	Copayment]	[+ waiver of Deductible]	[+ waiver of
Person]]			Deductible]
	[+ waiver of		
	Deductible]		
[limited to one (1) visit per day]			
c. [Occupational Therapy] ^[1]	[Copayment]	[Copayment]	[Copayment]
[Maximum Benefit [\$500-2,000]	[%Coinsurance]	[% Coinsurance]	[% Coinsurance]
[combined] [each] [PT] [OT] [ST]]	[after	[after Copayment]	[after Copayment]
[Maximum of [5-30] visits [per Injury] [per	Copayment]		
Sickness] [per Policy Year], [per Covered		[+ waiver of Deductible]	[+ waiver of
Person]]	[+ waiver of		Deductible]
	Deductible]		
d. [Cardiac/Pulmonary] ^[1]	[Copayment]	[Copayment]	[Copayment]
[Maximum We will pay is \$[500-2,000] per	[%	[% Coinsurance]	[% Coinsurance]
Injury] [per Sickness] [per Policy Year], [per	Coinsurance]	[after Copayment]	[after Copayment]
Covered Person]]	[after		
	Copayment]	[+ waiver of Deductible]	[+ waiver of
			Deductible]
	[+ waiver of		
	Deductible]		

Covered Services	[SHC]	In-Network Benefit Level	Out-of-Network Benefit Level
e. [Chiropractic] ^[1]	[Copayment]	[Copayment]	[Copayment]
[Maximum Benefit \$[Copayment] per visit;] \$[500-2,000] [combined] [each] [PT] [OT] [ST]] [per Condition][per Policy Year]	[% Coinsurance]	[% Coinsurance]	[% Coinsurance]
	[after Copayment]	[after Copayment]	[after Copayment]
[Maximum of [5-30] visits [per Injury] [per Sickness] [per Policy Year], [per Covered Person]]	[+ waiver of Deductible]	[+ waiver of Deductible]	[+ waiver of Deductible]
[limited to one (1) visit per day]			
f. [Acupuncture] ^[1]	[Copayment]	[Copayment]	[Copayment]
[Maximum Benefit \$[Copayment] per visit;] \$[500-2,000] [per Injury] [per Policy Year], [per Covered Person]]	[% Coinsurance]	[% Coinsurance]	[% Coinsurance]
	[after Copayment]	[after Copayment]	[after Copayment]
[Maximum of [5-30] visits [per Injury] [per Sickness] [per Policy Year], [per Covered Person]]	[+ waiver of Deductible]	[+ waiver of Deductible]	[+ waiver of Deductible]
[limited to one (1) visit per day]			
g. [Acupuncture and Chiropractic Combined] ^[1]	[Copayment]	[Copayment]	[Copayment]
[Maximum Benefit \$[Copayment] per visit;] \$[500-2,000] [per Injury] [per Policy Year], [per Covered Person]]	[% Coinsurance]	[% Coinsurance]	[% Coinsurance]
	[after Copayment]	[after Copayment]	[after Copayment]
[Maximum of [5-30] visits [per Injury] [per Sickness] [per Policy Year], [per Covered Person]]	[+ waiver of Deductible]	[+ waiver of Deductible]	[+ waiver of Deductible]
[limited to one (1) visit per day]			
h. [Podiatry]	[Copayment]	[Copayment]	[Copayment]
[Maximum Benefit \$[Copayment] per visit;] \$[500-2,000] [per Injury] [per Policy Year], [per Covered Person]]	[% Coinsurance]	[% Coinsurance]	[% Coinsurance]
	[after Copayment]	[after Copayment]	[after Copayment]
[limited to one (1) visit per day]	[+ waiver of Deductible]	[+ waiver of Deductible]	[+ waiver of Deductible]

	Covered Services	[SHC]	In-Network Benefit Level	Out-of-Network Benefit Level
2.	[Home Health Care services] ^[1] [The maximum We will pay is [10-100] visits per Injury] [per Sickness] [per Policy Year], [per Covered Person] [(four (4) hours or less = one (1) visit)]	[Not Applicable]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]
OR	[The maximum We will pay is \$[50-500]per Injury] [per Sickness] [per Policy Year], [per Covered Person] [(four (4) hours or less = one (1) visit)]			
3.	[Hospice] ^[1] [The maximum We will pay for bereavement services is [60, 90] days following the Covered Person's date of death] The maximum We will pay is [\$5000] per Injury] [per Policy Year], [per Covered Person]] [per lifetime]	[Not applicable]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]
4.	[Diabetic education] ^[1] [The maximum We will pay is \$[250-1,000] (per Injury) [per Sickness] [per Policy Year], [per Covered Person]]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]
5.	[Nutrition Counseling] ^[1] [The maximum We will pay is \$[250-1,000] [per Sickness] [per Policy Year], [per Covered Person]]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]
6.	[Prosthetic Appliances] ^[1] [The maximum We will pay for Prosthetics is \$[250-5,000][per Injury] [per Sickness] [per Policy Year], [per Covered Person]]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]

	Covered Services	[SHC]	In-Network Benefit Level	Out-of-Network Benefit Level
7.	[TMJ] [The maximum We will pay is \$[250-1,000] [per Injury] [per Sickness] [per Policy Year], [per Covered Person]]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]
8.	[PKU Testing & treatment]	[Not applicable]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]
9.	[Durable Medical Equipment] ^[1] [The maximum We will pay is \$[100-5,000] [per Injury] [per Sickness] [per Policy Year], [per Covered Person]] [Includes temporary surgical appliances]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]
10.	[Emergency Medical Transportation services] ^[1] [The maximum We will pay is \$[500-5,000] [per Injury] [per Sickness] [per Policy Year], [per Covered Person]] [Per Trip]	[Not applicable]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]
11.	[Eye Refractions, when performed in conjunction with a chronic or acute medical Condition. Note: Must be associated with an Illness code.]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]

Covered Services	[SHC]	In-Network Benefit Level	Out-of-Network Benefit Level
12. [Repair of eye glasses, contact lens or hearing aids when required as a direct result of an Injury]	[Copayment]	[Copayment]	[Copayment]
	[% Coinsurance]	[% Coinsurance]	[% Coinsurance]
[The Maximum We will pay is \$[25-500] [per Injury] [per Sickness] [per Condition] [per Policy Year]]	[after Copayment]	[after Copayment]	[after Copayment]
	[+ waiver of Deductible]	[+ waiver of Deductible]	[+ waiver of Deductible]
13. Dental treatment due to Injury to Teeth [not including [broken fillings] [or] [damage caused by biting or chewing]	[Copayment]	[Copayment]	[Copayment]
	[% Coinsurance]	[% Coinsurance]	[% Coinsurance]
	[after Copayment]	[after Copayment]	[after Copayment]
[The Maximum We will pay is \$[100-300] per tooth] [and] \$[250-1000] per Injury]	[+ waiver of Deductible]	[+ waiver of Deductible]	[+ waiver of Deductible]
[treatment must be received within [5-90 days of Injury]		[If an In-Network facility is utilized, Out-of-Network Provider claims will be processed at the In-Network benefit level once R&C is established.]	

Covered Services	[SHC]	In-Network Benefit Level	Out-of-Network Benefit Level
14. [Blood and Body Fluid Needlestick Exposure]	[Copayment]	[Copayment]	[Copayment]
[The maximum We will pay is \$[1,000-25,000] [per exposure] [per Injury] [per Illness] [per Covered Person], [per Policy year.]]	[% Coinsurance]	[% Coinsurance]	[% Coinsurance]
	[after Copayment]	[after Copayment]	[after Copayment]
<ul style="list-style-type: none"> Coverage is for academic-related exposures only No referrals needed Covered in any geographic location in any medical facility 100% reimbursement for: <ul style="list-style-type: none"> a. Physician visits b. Lab tests done on the Student and the patient/donor involved in the exposure c. Emergency room visits, if necessary d. Medications necessary to treat exposure 	[+ waiver of Deductible]	[+ waiver of Deductible]	[+ waiver of Deductible]

[Enrollment:

1. Visiting medical Students must submit payment for this insurance Premium. The Needlestick Insurance enrollment form should be filled out and submitted with payment (by check or credit card authorization) with you visiting medical Student application. Checks should be made out to **[Nationwide Life Insurance Co.]**.
2. Coverage will start the first day of the visiting medical Student's rotation, if the Premium is received by [TPA name]. The Needle-Stick Insurance enrollment form and payment should be submitted at least three weeks prior to the start date of the rotation for processing.
3. This information will be recorded in the Student Health Center (SHC) medical database and forwarded to [TPA name.], for processing.
4. An exposure (yellow) card for reference and Coverage confirmation will be given to the visiting medical Student at orientation on the first day.
5. Visiting medical Students may use the SHC for Coverage under this plan only.

Coverage under this plan will end on the last day of the visiting medical Student's rotation]

Covered Services	[SHC]	In-Network Benefit Level	Out-of-Network Benefit Level
[Retail Prescription Drugs - per prescription or refill [, subject to dispensing limits.]	[[30-80]% of charges] [[50-100]% after a Copayment of: \$[5-50] for each 30-day supply, \$[8-90] for each 60-day supply or \$[10-140] for each 90-day supply, if filled at SHC or if the SHC does not carry the drug, the SHC is closed, or when filled outside of a [25-50]-mile radius of the SHC] [brand name or Generic prescriptions for Accutane will be paid at [25-75]%]	[30-80% of charges] [[50-100]% after a Copayment of: \$[5-50] for each 30-day supply, \$[8-90] for each 60-day supply or \$[10-140] for each 90-day supply]	[30-80% of charges]
<ul style="list-style-type: none"> Generic Drugs (Tier 1) 	[% Coinsurance after [\$0, 10,15, 20] Copayment]	[50-100% Coinsurance + waiver of Deductible after] [\$10, 20, 25, 35, 45, 50] Copayment] [Accutane is subject to a [25-50]% Copayment]	[[% Coinsurance + waiver of Deductible after] [\$10, 20] Copayment] [Not covered]

Covered Services	[SHC]	In-Network Benefit Level	Out-of-Network Benefit Level
Note: Tier 2 has two option A or B			
<ul style="list-style-type: none"> [Formulary Brand Drugs (Tier 2)] 	[% Coinsurance after]	[% Coinsurance + waiver of Deductible after]	[% Coinsurance]
OR	[\$15, 20, 25, 30, 35, 50] Copayment]	[\$20, 25, 35, 45, 50] Copayment]	[Not covered]
<ul style="list-style-type: none"> [Formulary Brand Drugs, Non Formulary Brand Drugs, [Specialty Drugs (Non-Formulary, new Drugs and self injectables)] (Tier 2)] 		\$[10-25] in the event there is no Generic replacement for a prescribed Brand Name drug] [Accutane is subject to a [25-50]% Copayment]	
<ul style="list-style-type: none"> [Specialty Drugs (Non-Formulary Brand Drugs, new Drugs, and self injectables) (Tier 3)] 	[% Coinsurance + waiver of Deductible after]	[% Coinsurance + waiver of Deductible after]	[Not covered]
	You pay [30-80]% Coinsurance, with a minimum of \$[50-100] up to a maximum of \$[150- 500]]	You pay [30-80]% Coinsurance, with a minimum of \$[50-100] up to a maximum of \$[150- 500]]	
Annual maximum [\$1,000-5,000] [per Policy Year]			
[Only a 30 day supply can be dispensed at any time.]			
[One (1) Copayment per thirty (30) day supply]]			
[includes prescription contraceptives]			
[Prescriptions for [anti-fungal nail and nail pad medication/Therapy, including but not limited to] Lamisil and Sporanox are not covered.]			
[anti-malarials for prophylaxis are covered]			
[the Deductible [, excess provision,] and Pre-existing Condition Limitation are waived for prescriptions filled at the SHC [, for a drug the SHC does not carry or when filled outside of a [25-50]-mile radius of the SHC].]			
[Diabetic Supply Benefit – Annual maximum, separate from the pharmacy benefit maximum [\$500,1000,1500,2000]]	[% Coinsurance after [\$0, 10,15, 20] Copayment]	[50-100% Coinsurance + waiver of Deductible after]	[[% Coinsurance + waiver of Deductible after]
The following supplies are covered:			
<ul style="list-style-type: none"> Blood glucose testing device, including those designed to assist the visually impaired (one every three years) 		[\$10, 20, 25, 35, 45, 50] Copayment]	[\$10, 20] Copayment]
<ul style="list-style-type: none"> Blood glucose testing strips 			[Not covered]
<ul style="list-style-type: none"> Ketone urine testing strips 			
<ul style="list-style-type: none"> Lancets and lancet puncture devices 			
<ul style="list-style-type: none"> Pen delivery systems for the administration of insulin 			
<ul style="list-style-type: none"> Insulin syringes] 			

Covered Services	[SHC]	In-Network Benefit Level	Out-of-Network Benefit Level
[Mail Service Prescription Drugs - per prescription or refill, [subject to dispensing limits 30 days, 60 days, 90 days]. (In-Network Benefit only)]			
<ul style="list-style-type: none"> Generic Drugs (Tier 1) 	Not applicable	[% Coinsurance + waiver of Deductible after] \$[10-50] Copayment]	Not covered
Note: Tier 2 has two option A or B			
Or <ul style="list-style-type: none"> [Formulary Brand Drugs (Tier 2)] [Formulary Brand Drugs, Non Formulary Brand Drugs, [Specialty Drugs (Non-Formulary, new Drugs and self injectables)] (Tier 2)] 	Not applicable	[% Coinsurance + waiver of Deductible after] \$[25-100] Copayment]	Not covered
<ul style="list-style-type: none"> [Specialty Drugs (Non-Formulary Brand Drugs, new Drugs, and self injectables) (Tier 3)] 	Not applicable	[% Coinsurance + waiver of Deductible after] You pay [30-80%] Coinsurance, with a minimum of \$[50-100] up to a maximum of \$[150-500] for a 30 day supply]	Not covered
[Repatriation of Remains The maximum We will pay is \$[5000-10,000], per Covered Person]			
[Family companion benefit is limited to \$[1,000-5,000]]			
[Medical Evacuation [to home [state] [country]] The maximum We will pay is \$[5000-25,000], per Policy Year, per Covered Person]			
[Family companion benefit is limited to \$[1,000-5,000]]			

SCHEDULE OF BENEFITS

[ACCIDENTAL DEATH [AND DISMEMBERMENT BENEFITS] [AND LOSS OF SIGHT BENEFITS]

For Loss of:	Benefit Amount Student	Benefit Amount Dependent
Life	[0-\$25,000]	[0-\$25,000]
Both hands or both feet [or the entire sight of both eyes]	[0-\$25,000]	[0-\$25,000]
One hand and one foot	[0-\$25,000]	[0-\$25,000]
One hand	[0-\$25,000]	[0-\$25,000]
One foot	[0-\$25,000]	[0-\$25,000]
One hand or one foot [or the entire sight of one eye]	[0-\$25,000]	[0-\$25,000]
More than one of the above Losses due to one Accident	[0-\$25,000]	[0-\$25,000]
Thumb or Index Finger	[0-\$25,000]	[0-\$25,000]

Note: Loss shall mean, with regard to hands or arms and feet or legs, dismemberment by severance at or above the wrist or ankle joint, and with regard to eyes, entire or irrecoverable Loss of sight.

Only the largest benefit will be paid if more than one Loss results from any one Accident.]

GENERAL DEFINITIONS

The terms listed below, if used, have the meaning stated.

Accident: An event that is sudden, unexpected, and unintended, and over which the Covered Person has no control.

[Accidental Injury: A specific unforeseen event, which happens while the Covered Person is covered under this Policy and which directly, and from no other cause results in an Injury.]

[Acupuncturist: A Licensed Acupuncturist (L.Ac.) who is authorized by law and duly licensed by the appropriate State Regulatory Agency to perform acupuncture who does not ordinarily reside in the Covered Person's home or is not related to the Covered Person by blood or marriage.]

[Ambulatory Surgical Center: A facility which meets licensing and other legal requirements and which:

- Is equipped and operated to provide medical care and treatment by a Doctor;
- Does not provide services or accommodations for overnight stays;
- Has a medical staff that is supervised full time by a Doctor;
- Has full-time services of a licensed Registered Nurse (R.N.) at all times when patients are in the facility;
- Has at least one operating room and one recovery room and is equipped to support any surgery performed;
- Has x-ray and laboratory diagnostic facilities;
- Maintains a medical record for each patient; and
- Has a written agreement with at least one Hospital for the immediate transfer of patients who develop complications or need confinement.]

[Anesthetist: A Doctor duly licensed according to state law, who administers the anesthesia agent during a surgical procedure.]

[Assistant Surgeon: A Doctor who assists the Surgeon who actually performs a surgical procedure.]

[Attending Doctor: A Doctor who is charged with the overall care of the patient and who is responsible for directing the treatment program.]

[Basic Medical Benefits: The maximum lifetime benefit amount payable by the Company for incurred Covered Charges for each Injury or Sickness. When Injury or Sickness requires treatment, payment shall be made for Covered Charges incurred.]

[Benefit(s): The extent of those services listed in the Covered Charges.]

[Brand Name Prescription Drugs: Drugs for which the drug manufacturer's trademark registration is still valid, and who's trademarked or proprietary name of the drug still appears on the package label.]

Coinsurance: The percentage of the expense for which the Company is responsible for a covered service. The Coinsurance is separate and not a part of the Deductible and Copayment.

[Coinsurance Maximum Limit: The maximum amount of money a Covered Person pays for Coinsurance amounts in a Policy Year. This amount is shown on the Schedule of Benefits. There are separate Coinsurance Maximum Limit amounts for In-Network and Out-of-Network Benefit Levels.]

Company: Nationwide Life Insurance Company. Also hereinafter referred to as We, Our and Us.

[Complications of Pregnancy: A Condition which:

- When pregnancy is not terminated, requires medical treatment and the diagnosis is distinct from pregnancy but is adversely affected by or is caused by pregnancy, such as: (a) acute nephritis; (b) nephrosis; (c) cardiac decompensation; (d) missed abortion; (e) preeclampsia/eclampsia; (f) puerperal infection; (g) R.H. Factor problems; (h) severe Loss of blood requiring transfusion; (i) and other similar medical and surgical Conditions of comparable severity related to pregnancy; or
- When pregnancy is terminated: (a) non-elective cesarean section; (b) ectopic pregnancy that is terminated; and (c) spontaneous termination of pregnancy during a period of gestation in which a viable birth is not possible.

Complications of Pregnancy will **not** include:

- False labor;
- Occasional spotting;
- Doctor prescribed rest during the period of pregnancy;
- Morning Sickness; and
- Similar Conditions associated with the management of a difficult pregnancy but which are not a separate Complication of Pregnancy.]

[Condition: Disease, Illness, ailment, malfunction, [or pregnancy] of a Covered Person.]

[Confinement/Confined: An uninterrupted stay following admission to a Health Care Facility. The re-admission to a Health Care Facility for the same or related Condition, within a 72 hour period, will be considered a continuation of the Confinement. Confined/Confinement does **not** include observation, which is a review or assessment of [23, 18] hours or less, of a person's Condition that does not result in admission to a Hospital or Health Care Facility.]

[Copayment: A specified dollar amount a Covered Person must pay for specified charges. The Copayment is separate from and not a part of the Deductible or Coinsurance or out-of-pocket maximum.]

[Cosmetic Surgery or Plastic Surgery: Surgery intended primarily to alter normal structures of the body to improve appearance and that will result in only minimal functional improvement, except for Reconstructive Surgery as defined in this Policy.]

Coverage: The right of the Covered Person to receive Benefits subject to the terms, Conditions, limitations and exclusions of the Policy.

[Covered Charge or Covered Expense: As used herein means those charges for any treatment, services or supplies: (a) for Network Providers not in excess of the Preferred Allowance; (b) for Non-Network Providers not in excess of the charges of the Reasonable and Customary expense therefore; and (c) not in excess of the charges that would have been made in the absence of this insurance; and (d) incurred while this Policy is in force as to the Covered Person [except with respect to any covered expense payable under the Extension of Benefits Provision.]]

Covered Person: A person:

- Who is eligible for Coverage as the Insured [or as a Dependent];
- Who has been accepted for Coverage [or has been automatically added];
- Who has paid the required Premium; and
- Whose Coverage has become effective and has not terminated.

Covered Services: Means the services and supplies, procedures and treatment described under Covered Services, subject to the terms, Conditions, limitations, and exclusions of the Policy.

[Creditable Coverage:

- Any individual or group Policy, contract or program, that is written or administered by a disability insurance Company, health care service plan, fraternal Benefits society, self-Insured employer plan, or any other entity, and that arranges or provides medical, Hospital, and surgical Coverage not designed to supplement other private or governmental plans. The term includes continuation or conversion Coverage but does not include accident only, credit, Coverage for onsite medical clinics, disability income, Medicare supplement, long-term care insurance, dental, vision, Coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical payment insurance, or insurance under which Benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance Policy or equivalent self-insurance.
- The Federal Medicare programs pursuant to Title XVIII of the Social Security Act.
- The Medicaid program pursuant to Title XIX of the Social Security Act.
- Any other publicly sponsored program, provided in this state or elsewhere, of medical, Hospital and surgical care.
- 10 U.S.C.A. Chapter 55 (commencing with Section 1071) (Civilian Health and Medical Program of the Uniformed services (CHAMPUS)).
- A medical care program of the Indian Health Service or of a tribal organization.
- A state health Benefits risk pool.
- A health plan offered under 5 U.S.C.A. Chapter 89 (commencing with Section 8901) (Federal Employees Health Benefits Program (FEHBP)).
- A public health plan as defined in federal regulations authorized by Section 2701(c)(1)(I) of the Public Health Service Act, as amended by Public Law 104-191, the Health Insurance Portability and Accountability Act of 1996.
- A health Benefit plan under Section 5(e) of the Peace Corps Act (22 U.S.C.A. Sec. 2504(e)).
- Any other Creditable Coverage as defined by subsection (c) of Section 2701 of Title XXVII of the federal Public Health Services Act (42 U.S.C. Sec. 300gg(c)).]

[Custodial Care: Care that is primarily for the purpose of meeting non-medical personal needs, such as help with the activities of daily living and taking medications. Activities of daily living include, but are not limited to, bathing, dressing or grooming, eating, toileting, walking, and getting in and out of bed. Custodial Care can usually be provided by someone without professional medical skills or training.]

[Deductible: The amount of expenses for Covered services and supplies which must be incurred by the Covered Person before specified Benefits become payable.]

[Dependent: A person who is the Insured's:

- Legally married spouse, who is not legally separated from the Insured and resides with the Insured Student.
- Domestic Partner who resides with the Insured Student
- [Child who is Dependent upon the Insured for support and maintenance and is under the age of [19-30].
- [Child who is Dependent upon the Insured for support and maintenance, is [19-30] through [22 - 30] years of age and is attending school full time, as determined by the school the Dependent is attending, including colleges and vocational, technical, vocational-technical or trade schools or institutes.

The term child refers to the Insured's unmarried:

- Natural child;
- Stepchild or foster child; A stepchild is a Dependent on the date the Insured marries the child's parent.
- Adopted child, including a child placed with the Insured for the purpose of adoption, from the moment of placement as certified by the agency making the placement.
- Foster child is a Dependent from the moment of placement with the Insured as certified by the agency making the placement.]

[Doctor: Any of the following to the extent they are authorized by law and duly licensed by the appropriate State Regulatory Agency to perform a particular service which is covered under the Policy: Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) who does not ordinarily reside in the Covered Person's home or is not related to the Covered Person by blood or marriage.]

[Domestic Partner: Two individuals who, together, each meet all of the following criteria set forth below:

1. Are 18 years of age or older.
2. Are competent to enter into a contract.
3. Are not legally married to, nor the Domestic Partner of, any other person.
4. Are not related by marriage.
5. Are not related by blood closer than permitted under marriage laws of the state in which they reside.
6. Have entered into the Domestic Partner relationship voluntarily, willingly, and without reservation.
7. Have entered into a relationship which is the functional equivalent of a marriage, and which includes all of the following:
 - living together as a couple;
 - mutual support of each other;
 - mutual caring and commitment to each other;
 - mutual fidelity;
 - mutual responsibility for each other's welfare; and
 - joint responsibility for the necessities in life.
8. Have been living together as a couple for at least six (6) months prior to obtaining the Coverage provided under this Policy and the Certificate.
9. Intend to continue the Domestic Partner relationship indefinitely, while understanding that the relationship is terminable at the will of either partner.]

[Drug Abuse means any chemical component that one inhales, ingests, injects, or applies to one's body for purposes of non-therapeutic use. Drug Abuse does not include alcoholism or alcohol abuse.]

[Durable Medical Equipment: A device which:

- Is primarily and customarily used for medical purposes, is specially equipped with features and functions that are generally not required in the absence of Sickness or Injury and is able to withstand repeated use;
- Is used exclusively by the patient;
- Is routinely used in a Hospital but can be used effectively in a non-medical facility;
- Can be expected to make a meaningful contribution to treating the patient's Sickness or Injury; and
- Is prescribed by a Doctor and the device is Medically Necessary for rehabilitation.

Effective Date: The first date a Student or a covered Dependent becomes covered under this Policy.

[Enhanced medical Aggregate Maximum Amount: The maximum amount of Benefits we will pay for any one Sickness or Injury under the Enhanced Major Medical expense Benefit while a Covered Person is covered under this Policy or any other Policy issued to the Policyholder by Us and is inclusive and cumulative of any and all periods of Coverage regardless of gaps in participation. The Major Medical Aggregate Maximum Amount is shown in the Schedule of Benefits.]

[Eligible Person: The Covered Person who is enrolled, [attending class] and meets the eligibility requirements of the Policyholder's school or [Dependents of the Covered Person].]

Emergency: A Sickness or Injury for which immediate medical treatment is sought at the nearest available facility. The Condition must be one which manifests itself by acute symptoms which are sufficiently severe (including severe pain) that a prudent layperson with average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in any of the following:

- Placing the health of the individual or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy;
- Serious impairment to bodily functions;
- Serious dysfunction of any bodily organ or part.

[Emergency Medical Transportation Services: A vehicle which is licensed solely as an ambulance by the local regulatory body to provide transportation to a Hospital or transportation from one Hospital to another for those individuals who are unable to travel to receive medical care by any other means or the Hospital cannot provide the

needed care. [Charges are payable only for transportation from the site of an Emergency to the nearest available Hospital that is equipped to treat the Condition].

[Enhanced Major Medical Benefits: The amount payable by the Company after the maximum Benefit has been paid under the Comprehensive Major Medical Benefit. The maximum Benefit payable shall be inclusive of the Comprehensive Major Medical Benefits, for each Injury or Sickness. When a Covered Person selects the Enhanced Major Medical Benefits, the Covered Person automatically has Coverage provided under the Comprehensive Major Medical Benefits. When Injury or Sickness requires treatment and after the Maximum Benefit has been paid under the Comprehensive Major Medical Benefit plan, payment shall be made at percentage for covered Medical expenses incurred under the Enhanced Major Medical Benefits plan.]

[Evaluation and Management: Professional services provided by a Doctor or Health Care Practitioner in the Doctor's office or in an out patient or other ambulatory facility.]

[Expense Incurred: The charge made for a service, supply, or treatment that is a Covered Service under the Policy. The expense is considered to be incurred on the date the service or treatment is given or the supply is received.]

[Experimental/Investigational: The service or supply has not been demonstrated in scientifically valid clinical trials and research studies to be safe and effective for a particular indication. For further explanation, see definition of Medically Necessary/Medical Necessity]

[Family Member: A person who is related to the Covered Person in any of the following ways: spouse, brother-in-law, sister-in-law, son-in-law, daughter-in-law, mother-in-law, father-in-law, parent (includes stepparent), brother or sister (includes stepbrother or stepsister), or child (includes legally adopted, step or foster child). A Family Member includes an individual who normally lives in the Covered Person's household.]

[Formula: Enteral products for use at home that are prescribed by a Doctor, Health Care Practitioner upon referral by a health care Provider authorized to prescribe dietary treatments, as medically necessary for the treatment of phenylketonuria (PKU).]

[Generic Drugs: A non-brand name drug, which is a pharmaceutical equivalent to a Brand Name Prescription Drug, sold at a lower cost.]

[Habilitative Treatment or Therapy: treatment or Therapy that develops or attempts to develop a function that did not previously exist, but would normally be expected to exist. treatment or Therapy is considered Habilitative if the function has achieved maximal or optimal improvement or is static, showing no progressive improvement with additional treatment.]

[Health Care Facility: A Student Health Center, Hospital, [Skilled Nursing, Sub-Acute,] Hospice, or other duly licensed, certified and approved health care institution which provides care and treatment for sick or injured persons.]

[Health Care Practitioner: Includes but is not limited to: A Doctor of Dentistry (D.D.S. or D.M.D.), Doctor of Podiatry (D.P.M.), Doctor of Optometry (O.D.), Doctor of Chiropractic (D.C.), Doctor's Assistant (P.A.), Psychologists (Ph. D.), Nurse (R.N. or L.P.N), which may include Nurse Midwife, Nurse Anesthetist, and Nurse Practitioner, a Licensed Clinical Social Worker (L.C.S.W.), Physical Therapist (P.T. or R.P.T.), Occupational Therapist (O.T.R.), Speech Pathologist, Audiologist, Marriage and Family Therapist (M.F.T. or M.S.W.), Respiratory Care Practitioner, or Registered Dietitian (R.D.) all of whom are (a) properly licensed or certified to provide medical care under the laws of the state of practice; (b) provide medical services within the scope of the license or certificate; and (c) does not ordinarily reside in the Covered Person's home or is not related to the Covered Person by blood or marriage.]

[Home Health Care: Services and supplies that is Medically Necessary for the care and treatment of a covered Illness or Accidental Injury that are furnished to a Covered Person at the Covered Person's residence.

Home Health Care consists of, but shall not be limited to, the following:

- Part-time or intermittent skilled nursing services provided by a Registered Nurse or licensed Vocational Nurse;
- Part-time or intermittent home health aide services which provide supportive services in the home under the supervision of a Registered Nurse or a Physical Therapist; and
- Physical therapy.]

[Home Infusion Therapy: The continuous Infusion of prescribed blended Drugs, as prescribed by the Attending Doctor, representing direct treatment of a specific covered Illness or Accidental Injury. The treatment is provided in the Covered Person's home.]

[Hospice: A coordinated plan of home and Inpatient care which treats the terminally ill patient and family as a unit. It provides care to meet the special needs of a family unit during the final stages of a terminal Illness and during the bereavement. Care is provided by a team of trained medical personnel, homemakers, and counselors. The team acts under an independent Hospice administration. It helps the family unit cope with physical, psychological, spiritual, social, and economic stresses.]

[Hospital: A facility which provides diagnosis, treatment, and care of persons who need acute Inpatient Hospital care under the supervision of Doctors. It must be licensed as a general acute care Hospital according to state and local laws. Hospital shall also include a psychiatric health facility for the treatment of mental or psychoneurotic disorders.

Facilities primarily treating drug addiction or alcoholism that are licensed to provide these services are also included in this definition. Hospital does not include an institution, or part thereof, which is other than incidentally a nursing home, a convalescent Hospital, or a place for rest or the aged.]

[Hospital Confined/Hospital Confinement: Confinement in a Hospital for at least [nineteen (19), twenty-four (24)] hours or greater for which a room and board charge is made by reason of Sickness or Injury for which Benefits are payable. The readmission for the same or related Sickness or Injury, within a seventy-two (72) hour period, will be considered a continuation of confinement.]

[Identification Card: Your Identification Card identifies You as a Covered Person.]

Illness: Sickness or disease.

[Infusion/Injectable Services: Services provided in an office or Outpatient facility, or by a licensed Infusion or health care agency, including the professional fee and related supplies. Infusion/Injectable Services does [not] include self-administered Injectable Drugs.]

Injury: Bodily Injury due to a sudden, unforeseeable, external event which:

- Results solely, directly and independently of disease, bodily infirmity or any other causes;
- [Occurs after the Covered Person's Effective Date of Coverage;]
- Occurs while Coverage is in force.

All injuries sustained in any one Accident, including all related Conditions and recurrent symptoms of these injuries, are considered a single Injury.

[In-Network Benefit Level: The highest level of payment made by Us for Covered Services under the terms of the Policy.]

[Inpatient/Inpatient Admission: A confinement of [nineteen (19), twenty-four (24)] hours or greater.]

[Insured: The Covered Person who is enrolled at and meets the eligibility requirements of the Policyholder's school [or Dependents of the Covered Person.]

[Lifetime Aggregate Maximum: The amount payable by the Company for incurred Covered Charges for all Injuries or Sicknesses and will never exceed an amount determined by subtracting from the sum of \$[10,000 to \$1,000,000] from the following: (i) all amounts paid under this Policy for all Injuries or Sicknesses; (ii) all amounts

paid to or in respect of an Insured for all Injuries or Sicknesses under any other Policy issued to the Policyholder by this Company, regardless of the Policy period of such other Policy.

The Maximum Benefit for all benefit Coverage afforded under this Policy is \$[10,000 to \$1,000,000] for all Injuries or Sicknesses. Covered Charges shall not include amounts paid by the Insured for Coinsurance.]

[Lifestyle Change: A change in Your or Your Dependent's status due to marriage, divorce, [dissolution of Domestic Partnership], age, birth, death, adoption, change in Spouse's [or Domestic Partner's] employment or health insurance or health plan Coverage, eligibility for Medicare, change in Student status or any other event which impacts eligibility for Coverage under the Policy.]

[Life-Threatening Condition: Diseases or Conditions where the likelihood of death is high unless the course of the disease is interrupted; or with potentially fatal outcomes, where the end point of clinical intervention is survival.]

[Loss: Medical expenses covered by this Policy as a result of Injury or Sickness as defined in this Policy.]

[Major Medical Aggregate Maximum Amount: The maximum amount of Benefits we will pay for any one Sickness or Injury under the Major Medical expense Benefit while a Covered Person is covered under this Policy or any other Policy issued to the Policyholder by Us and is inclusive and cumulative of any and all periods of Coverage regardless of gaps in participation. The Major Medical Aggregate Maximum Amount is shown in the Schedule of Benefits.]

[Maximum Benefit: The maximum payment We will make under the Policy for each Covered Person for Covered Services. This amount is shown on the Schedule of Benefits.]

[Medical Emergency: The unexpected onset of an Injury or Sickness which requires immediate or urgent medical attention which, if not provided, could result in a Loss of life or serious permanent damage to a limb or organ or pain sufficient to warrant immediate care. A Medical Emergency does not include elective surgery, elective treatment or routine care.]

[Medically Necessary/Medical Necessity: A treatment, drug, device, procedure, supply or service that is necessary and appropriate for the diagnosis or treatment of Sickness or Injury in accordance with generally accepted standards of medical practice in the United States at the time it is provided. [When specifically applied to Hospital Confinement, it means that the diagnosis or treatment of symptoms or a Condition cannot be safely provided on an Outpatient basis.

A treatment, drug, device, procedure, supply or service shall not be considered as Medically Necessary if it:

- Is Experimental/Investigational or for research purposes;
- Is provided solely for educational purposes or the convenience of the patient, the patient's family, Doctor, Hospital or any other Provider;
- Exceeds in scope, duration or intensity that level of care that is needed to provide safe, adequate and appropriate diagnosis or treatment and where ongoing treatment is merely for maintenance or Preventive Care;
- Could have been omitted without adversely affecting the patient's Condition or the quality of medical care;
- Involves treatment with or the use of a medical device, drug or substance not formally approved by the U.S. Food and Drug Administration (FDA). If the prescribed drug is recognized as safe and effective for the treatment of a Sickness or Injury by one or more of the Standard Medical Reference Compendia or in the Medical Literature, even if the prescribed drug has not been approved by the FDA for the treatment of that specific Sickness or Injury, Coverage will be provided, subject to the exclusions and limitations of the Policy;
- Involves a service, supply or drug not considered reasonable and necessary by the Healthcare Financing Administration Medicare Coverage Issues Manual; or
- Can be safely provided to the patient on a more cost-effective basis such as Outpatient, by a different medical professional, or pursuant to a more conservative form of treatment.

We reserve the right to determine whether a service, supply or drug is Medically Necessary.]

[Mental Disorder: Nervous, emotional, and mental disease, illness, syndrome or dysfunction classified in the most recent addition of the Diagnostic and Statistical Manual of Mental Disorders (DSM IV) or its successor, as a Mental Disorder on the date of medical care or treatment is rendered to a Covered Person.]

[Network Providers: Doctors, Hospitals and other healthcare Providers who have contracted to provide specific medical care at negotiated prices.]

[Non-Network Providers: Have not agreed to any pre-arranged fee schedules.]

[Nurse: A licensed Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.) who: (a) is properly licensed or certified to provide medical care under the laws of the state where the nurse practices; and (b) provides medical services which are within the scope of the nurse's license or certificate who does not ordinarily reside in the Covered Person's home or is not related to the Covered Person by blood or marriage.]

[Office Surgery (ies): An invasive procedure to repair, replace, remove or add tissue or fluid. The procedural coding represents that found under the surgical codes as outlined in the Current Procedural Terminology Manual (CPT).]

[Orthognathic Surgery: A surgical procedure which reconstructs the bones of the jaw. Facial reconstructive surgery is covered when the Covered Person has a defect or deformity of the facial and/or jawbones (documented by CT/MRI/or x-ray) that may be life threatening or documented to be proposed for a medical physiological functional impairment presently being addressed. Usual causes of such acquired Conditions include local trauma, infection, neoplasm, inflammatory processes or vascular insufficiency which result in destruction or deformity of the affected bone. This does not include oral appliances/orthotics.]

[Other Medical Care Practitioner: Upon referral by a Doctor, a licensed Clinical Social Worker (L.C.S.W.), Physical Therapist (P.T. or R.P.T.), Occupational Therapist (O.T.R.), Speech Pathologist, Audiologist, Marriage and Family Therapist (M.F.T. or M.S.W.), Respiratory Care Practitioner, or Registered Dietitian (R.D.), who does not ordinarily reside in the Covered Person's home or is not related to the Covered Person by blood or marriage.]

[Out-of-Network Benefit Level: The lowest level of payment made by Us for Covered Services under the terms of the Policy.]

[Outpatient: Not confined in a Hospital, Skilled Nursing facility or Hospice as a registered bed patient.]

[Partial Hospital Mental Health Confinement: A structured program of active treatment for psychiatric care for Mental Disorders, alcoholism and/or Drug Abuse and/or addiction received on an Outpatient basis at a Hospital. Such program may include, but is not limited to, Doctor or Other Medical Care Practitioner visits, dietary counseling, physical activities, and room and meal services. This includes day treatment or residential treatment centers.]

[Per Condition Aggregate Maximum: The amount payable by the Company for incurred Covered Charges for each Injury or Sickness and will never exceed an amount determined by subtracting from the sum of \$[10,000 to \$1,000,000] following: (i) all amounts paid under this Policy for each Injury or Sickness; (ii) all amounts paid to or in respect of an Insured for each Injury or Sickness under any other Policy issued to the Policyholder by this Company, regardless of the Policy period of such other Policy.]

Policy: The agreement between Us and the Policyholder which states the terms, Conditions, limitations and exclusions regarding Coverage.

Policy Year: The period of twelve (12) months following the Policy's Effective Date.

[Policy Year Maximum Limit: The maximum payment We will make under the Policy for each Covered Person for Covered Services.]

Policyholder: The entity shown as the Policyholder on the Policy face page.

[Pre-admission Testing: Tests done in conjunction with a scheduled surgery where a operating room has been reserved before the tests are done.]

[Pre-existing Condition: A Sickness or Injury for which [symptoms,] medical care, treatment, diagnosis or advice was received or recommended within the [three (3), six (6), twelve (12)] consecutive months prior to the Covered Person's Effective Date of Coverage under the Policy. Pre existing Condition means any Condition [(a) that would have caused an ordinary prudent person to seek medical advice, diagnosis, care or treatment during the [three (3), six (6), twelve (12)] months immediately prior to an Insured's Effective Date of Coverage;] [(b) for which medical advice, diagnosis, care or treatment was recommended or received within the [three (3), six (6), twelve (12)] months immediately prior to an Insured's Effective Date of Coverage; or] [(c) a pregnancy existing on the Insured's Effective Date of Coverage.]

[Preferred Allowance: The amount a Network Provider has agreed to accept as payment in full for Covered Charges.]

[Preferred Provider Organization or PPO: The entity named in the Schedule of Benefits.]

[Premium: The amount required to maintain Coverage for each Eligible Person and Dependent in accordance with the terms of this Policy.]

[Prescription Drugs: Drugs which may only be dispensed by written prescription under Federal law, and approved for general use by the U.S. Food and Drug Administration (FDA). The Drugs must be dispensed by a licensed pharmacy Provider for out of Hospital use. Coverage for a Prescription Drug will not be excluded for a particular indication on the grounds that the drug has not been approved by the FDA for that indication, if such drug is recognized for treatment of such indication in one of the standard reference compendia or in the medical literature as recommended by current American Medical Association (AMA) policies. Prescription Drug Coverage shall also include Medically Necessary supplies associated with the administration of the drug.]

[Preventive Care: Comprehensive Preventive Care of Dependent children:

- That is consistent with the most current version of the Recommended Childhood Immunization Schedule/United States, jointly adopted by the American Academy of Pediatrics, the Advisory Committee on Immunization Practices, and the American Academy of Family Doctors; and
- Provides for periodic health evaluations, immunizations and laboratory services in connection with periodic health evaluations.]

[Provider: A Doctor, Health Care Facility, Urgent Care Facility, or Health Care Practitioner that is licensed or certified to provide medical services or supplies.]

[Rehabilitative: The process of restoring a person's ability to live and work after a disabling Condition by:

- Helping the person achieve the maximum possible physical and psychological fitness;
- Helping the person regain the ability to care for himself or herself;
- Offering assistance with relearning skills needed in everyday activities, with occupational training and guidance and with psychological readjustment.]

[Reasonable and Customary expense: The most common charge for similar professional services, drugs, procedures, devices, supplies or treatment within the area in which the charge is incurred, so long as those charges are reasonable. The most common charge means the lesser of:

- The actual amount charged by the Provider;
- [The negotiated rate, if any; or]
- The charge which would have been made by the Provider of medical services for a comparable service or supply made by other Providers in the same geographic area, as reasonably determined by Us for the same service or supply.

Geographic area means the first three digits of the zip code in which the service, treatment, procedure, drugs or supplies are provided or a greater area, if necessary, to obtain a representative cross-section of charge for a like treatment, service, procedure, device, drug or supply.

Reasonable charges, fees or expenses as used herein to describe expense, will be considered to mean the percentile of the payment system in effect on the Effective Date as shown on the face page of this Policy.

No payment will be made under this Policy for any expenses incurred which in the judgment of the Company are in excess of Reasonable and Customary expense.]

[Reconstructive Surgery: Surgery performed to correct or repair abnormal structures of the body caused by [congenital defects,] developmental abnormalities, trauma, infection, tumors, disease, or Accidental Injury occurring while Insured under this Policy to either: (1) improve function or (2) create a normal appearance.]

[Reservist: A member of a reserve component of the Armed Forces of the United States. Reservist also includes a member of the State National Guard and the State Air National Guard.]

[Review Organization: Entity named in the Schedule of Benefits.]

[Screening Mammography: A radiological examination utilized to detect unsuspected breast cancer at an early stage in asymptomatic women and includes the x-ray or digital radiography examination of the breast using equipment that is dedicated specifically for mammography, including, but not limited to the x-ray tube, filter, compression device, screens, film, and cassettes, and that has an average radiation exposure delivery of less than one rad mid-breast. Screening Mammography includes two views for each breast and includes the professional interpretation of the films. Screening Mammography does not include diagnostic mammography. Screening Mammography must be performed in a facility or mobile mammography screening unit that is accredited under the American College of Radiology Mammography Accreditation Program or in a Hospital.]

[Serious Emotional Disturbance of a Child: A child under the age of [0-18] who has one or more mental disorders as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, other than a primary substance use disorder or developmental disorder that result in behavior inappropriate to the child's age according to expected developmental norms.]

[Severe Mental Illness: Schizophrenia; schizoaffective disorder; bipolar disorder (manic-depressive Illness); major depressive disorders; panic disorder; obsessive-compulsive disorder; pervasive developmental disorder or autism; anorexia nervosa; and bulimia nervosa.]

[Sickness: Illness, disease, pregnancy and Complications of Pregnancy. All related Conditions and recurrent symptoms of the same or a similar Condition will be considered the same Sickness.]

[Skilled Nursing Care: Services that are certified as Medically Necessary by a Doctor and are not intermediate, domiciliary, custodial or retirement care.]

[Skilled Nursing Facility: A place (including a separate part of a Hospital) which:

- Regularly provides room and board for person(s) recovering from Illness or Accidental Injury;
- Provides continuous twenty-four (24) hour nursing care by or under the supervision of a Registered Nurse;
- Is under the supervision of a duly licensed Doctor;
- Maintains a daily clinical record for each patient;
- Is not, other than incidentally, a place for rest, the aged, place of treatment for alcoholism or drug and/or substance abuse or addiction; and
- Is operated pursuant to law.]

[Special Food Product: A food product that is both of the following: (a) prescribed for the treatment of phenylketonuria (PKU) and is consistent with the recommendations of best practices of qualified health professionals with expertise to, and experience in the treatment and care of PKU. It does not include food that is naturally low in protein, but may include a food product that is specially formulated to have less than one gram of protein per serving; and (b) used in place of normal food products, such as grocery store foods, used in the general population.]

[Specialty Drugs: Means a drug or category of drugs that meet any of the following criteria: the drug (i) is produced through biotechnology or recombinant DNA technology mechanism, (ii) is considered to be high cost, (iii)

is self administered by injection and/or Infusion or (iv) requires special patient monitoring, or (v) requires special handling or (vi) has restricted distribution procedures.]

[Student: A registered Student, [resident] [fellow]. [postdoctoral fellow], [domestic], [international Student] who is enrolled in a participating college, [taking at least [1-15] credit hours or more] and [is physically and actively attending classes for at least [1-31] days after their Effective Date of Coverage under the Policy]..

[Sub-Acute Facility: A free-standing facility or part of a Hospital that is certified by Medicare to accept patients in need of Rehabilitative and Skilled Care Nursing.]

[Surgeon: A Doctor who actually performs surgical procedures.]

[Surgical Services: Surgical Services include both facility and Provider fees associated with any surgery, whether done as an Inpatient, Outpatient or in a Doctor's office. Benefits are paid at the Surgical Services Benefit shown on the Schedule of Benefits services include:

- Surgeon and Assistant Surgeon
- Anesthesia
- Facility fees
- Supplies, drugs, and miscellaneous items used in association with the surgical event.]

[Surrogate Parenting Agreement: One in which a woman agrees to become pregnant with the intent of surrendering custody of the child.]

[Teeth: The major portion of the individual tooth which is present, regardless of filings and caps; and is not carious, abscessed, or defective.]

[Urgent Care: Means short-term medical care for non-life threatening Conditions that can be mitigated or require care within [forty-eight (48) or seventy-two (72)] hours of onset.]

[Urgent Care Facility: a Hospital or other licensed facility which provides diagnosis, treatment, and care of persons who need acute care under the supervision of Doctors.]

[Vision Screening: A screening to determine if there are underlying medical Conditions or if a refractive exam needs to be performed. Vision Screening does not include refractive exams, which are not covered as specified in the General Exclusions and Limitations.]

We, Our and Us: Nationwide Life Insurance Company.

[You and Your: the Covered Person.]

Male pronouns whenever used include female pronouns

ELIGIBILITY

We maintain the right to investigate Student status and attendance records to verify that the Policy eligibility requirements have been met. If We discover that the Policy eligibility requirements have not been met, Our only obligation is refund of Premium.

All registered Students who pay [full registration fees] and [actively attend class] or [have matriculated] at the Policyholder's school for at least the first [thirty-one (0-31)] days of the Policy Term are [eligible to enroll] [are automatically enrolled] in the Policy [for the Fall, Winter, Spring] [for the Fall, Winter, Spring, and Summer Terms] [for the term enrolled]. Except in the case of medical withdrawal due to Sickness or Injury, any Student withdrawing from school during the first [thirty-one (0-31)] days of the period for which Coverage is purchased, will not be covered under this Policy and a full refund of Premium will be made minus the cost of any claim Benefits made by Us. Students withdrawing after such [thirty-one (0-31)] days will remain covered under the Policy for the term purchased and no refund will be allowed.

Each Student, as determined by the school and the Company, is eligible for Coverage under this Policy.

[CREDIT HOUR REQUIREMENTS]

Students registered for more than [one (1) –fifteen (15)] credits in a quarter/semester.

[Scholars, visiting and otherwise defined by the school]

[The following courses are excluded from being applied towards the required minimum credit hours:

- Distance Learning Courses
- Courses taken as audit
- Courses taken as Pass/Non-Pass
- Courses taken Grad Non-Degree
- Home Study
- Correspondence
- TV courses]

[DEPENDENTS ACQUIRED AFTER EFFECTIVE DATE]

Newborn Children: An Insured's newborn child is automatically covered from the moment of birth until such child is **ninety (90)** days old. Coverage for such child will be for Sickness and Injury, including medically diagnosed congenital defects, birth abnormalities, prematurity and nursery care. However, the Insured must notify Us in writing within thirty-one (31) days of such birth and pay the required additional Premium, if any, in order to have Coverage for the newborn child continue beyond such **ninety (90)** day period.

Step-Child: Coverage for a Step-Child is effective on the date the Insured marries the child's parent. However, the Insured must notify Us in writing within thirty-one (31) days of the marriage and pay the required additional Premium, if any, in order to have Coverage for the child continue beyond such thirty-one (31) day period.

Foster Child: Coverage for a Foster Child is effective upon the date of placement with the Covered Person. Coverage for such child will be for Sickness and Injury, including medically diagnosed congenital defects, birth abnormalities, prematurity and nursery care. Coverage will continue unless the placement is disrupted and the child is removed from placement. However, the Insured must notify Us in writing within thirty-one (31) days of such placement and pay the required additional Premium, if any, in order to have Coverage for the Foster Child continue beyond such thirty-one (31) day period.

Adopted Child: Coverage for an adopted child is effective upon the earlier of the date of placement for the purpose of adoption, **the date the petition to adopt is filed as long as the Insured notifies us within 60 days**, or the date of the entry of an order granting the adoptive parent custody of the child for purposes of adoption. Coverage for such child will be for Sickness and Injury, including medically diagnosed congenital defects, birth abnormalities, prematurity and nursery care. Coverage will continue unless the placement is disrupted prior to legal adoption and the child is removed from placement. However, the Insured must notify Us in writing within thirty-one (31) days of such adoption and pay the required additional Premium, if any, in order to have Coverage for the adopted child continue beyond such thirty-one (31) day period.

Dependent Spouse/Domestic Partner: A Dependent spouse or Domestic Partner is eligible for Coverage on the date of marriage to the Insured or the date the Domestic Partnership begins. Enrollment and Premium must be received within thirty-one (31) days of the marriage or the date the Domestic Partnership begins. Coverage is effective upon enrollment and receipt of Premium by Us or Our authorized representative.]

TERMINATION

Policyholder: The Policy is issued for the Policy term stated on the face page of this Policy on the Effective Date of the Policy. If the Policyholder desires to continue Coverage, We will issue a new Policy for a new Policy term, subject to the then current underwriting requirements.

Covered Person: Coverage will terminate at 12:01 a.m. standard time at the Covered Person's residence on the earliest of:

- The termination date of the Policy;
- The date the Insured ceases to be an Eligible Person;
- [The day after the last day of study in the sponsored program;]
- [The date of departure to the United States;]
- The last day of the [term of Coverage] [Policy term] for which Premium is paid;
- The date the Covered Person departs the Policyholder's school for their home country for a period in excess of [thirty (30), sixty (60), ninety (90)] consecutive days. No Benefits will be payable for any medical treatment received in the Covered Person's Home Country.
- The last date of the period for which Premium has been paid following the date a Dependent ceases to be a Dependent as defined;
- The date a Covered Person enters full time active military service. [Upon written request [within [fifteen (15) – sixty (60)] days of leaving school], We will refund any unearned pro-rata Premium with respect to such person.] [We will refund the unearned pro-rata Premium to such person upon request.]
- Handicapped Dependent child who is not capable of supporting himself or herself due to mental retardation or physical handicap will be continued beyond the age at which Coverage would otherwise have terminated if:
 1. The Dependent child became incapacitated prior to the age at which Coverage would otherwise have terminated; and
 2. The Dependent child is primarily Dependent on the Eligible Person for support and maintenance; and
 3. Proof of such incapacity and dependence is given to Us by a Doctor. Proof must also be given to Us annually.

Coverage will continue as long as the Dependent continues to be so incapacitated and Dependent, unless otherwise terminated in accordance with the terms of the Policy.

[Termination is subject to the Extension of Benefits provision.]

[EXTENSION OF BENEFITS]

The Coverage provided under this Policy ceases on the termination date, shown on the face page. However, if an Insured is [Hospital Confined on the termination date from a covered Injury or Sickness for which Benefits were paid before the termination date] or [Totally Disabled on the termination date from a covered Injury or Sickness for which Benefits were paid before the termination date], Covered expenses for such Injury or Sickness will continue to be paid for a period of [thirty (30), sixty (60), ninety (90)] days or [until date of discharge], whichever is earlier.

[With respect to the Insured, the inability to attend classes at the location where enrolled].

The total payments made in respect of the Insured for such Condition both before and after the termination date will never exceed the Maximum Benefit. After this Extension of Benefits provision has been exhausted, all Benefits cease to exist and under no circumstances will further Benefits be made.

[Dependents that are newly acquired during the Insured Student's Extension of Benefits period are not eligible for Benefits under the provision.]

[CONTINUATION OF COVERAGE]

The right to continue this Coverage is available to an Insured who is no longer an Eligible Person. Application for continued Coverage for the Insured and his/her previously Insured Dependents must be made within thirty (30) days of termination of Coverage. If continuous Coverage is maintained, Coverage may be continued for up to an additional [three (3), six (6), twelve (12)] months. Continuation of Coverage will be subject to the terms of the Policy.

[REINSTATEMENT OF RESERVIST AFTER RELEASE FROM ACTIVE DUTY]

If your insurance or your eligible Dependent's insurance ends due to your being called or ordered to active duty, such insurance will be reinstated without any waiting period when you return to school and satisfy the eligibility requirements defined by the Policyholder.

COVERED SERVICES

Subject to the terms, Conditions, limitations, and exclusions of the Policy, payment will be considered for expenses Incurred for the Covered Services described in this section. [All Benefits are per [Policy Year/per Injury or Sickness] unless otherwise indicated]. Except for well baby and child care [and well adult care], all Covered Services must be Medically Necessary. For details on Benefit limits, Deductible, Copayment, and Coinsurance amounts please refer to the Schedule of Benefits.

Wellness Covered Services

1. [Well Baby and Child Care ages [zero (0)-eighteen (18)] and under:
Benefits will be considered based on the following:
 - a. The Recommendations for Preventive Pediatric Health Care, as adopted by the American Academy of Pediatrics;
 - b. The most current version of the Recommended Childhood Immunization Schedule/United States, jointly adopted by the American Academy of Pediatrics, the Advisory Committee on Immunization Practices, and the American Academy of Family Doctors.

The Covered Services are:

- Periodic health evaluations;
- Immunizations;
- Laboratory services in connection with periodic health evaluations;
- Hearing screening as recommended by the American Academy of Pediatrics;
- One (1) Vision Screening per Policy Year;
- Screening for blood lead levels]

Wellness Covered Services

2. [Well Adult Care ages [seven (7)- seventeen (17)] and over - Subject to the Benefit limits shown on the Schedule of Benefits for the following Covered Services:
 - [Routine physical examinations;]
 - [Routine gynecological care, including an annual cervical cancer screening;]
 - [PPD TB Test]
 - [Dexascan screening]
 - [One prostate specific antigen test (PSA) and one digital rectal exam per Policy Year, for men];
 - [Chest x-ray and routine laboratory services];
 - [One (1) Screening Mammography per Policy Year for a Covered Person age thirty-five (35) or older];
 - [the most current version of the Recommended Adult Immunization/vaccines as recommended by the Centers for Disease Control, the Advisory Committee on Immunization Practices, and the American Academy of Family Doctors.]
 - [Or- The following list of immunizations: [Tetanus], [Measles-Mumps-Rubella], [Travel inoculations], [Hepatitis A], [Hepatitis B], [HPV], [Flu], [Pneumonia], [Varicella] [Meningococcal], [Twinrix (combination Hepatitis A and Hepatitis B)].]

Outpatient Covered Services

1. [Doctor office visits [limited to one (1) visit per day] for the diagnosis, medical advice, care or treatment of a Condition (other than for pregnancy and for mental health [(including Severe Mental Illness and Serious Emotional Disturbance of a Child),] and Drug and Alcohol Abuse). [(Evaluation and Management are subject to a Copayment; all other services performed in the Doctor's office are subject to Coinsurance)]]
2. [Diagnostic services performed and billed by a Doctor's office, including ultrasounds and amniocentesis;]
3. [Independent lab services, Outpatient facility and related Doctor services, including x-ray and lab services which are diagnostic or therapeutic and including ultrasounds and amniocentesis;]
Diagnostic Imaging and Laboratory procedures],
4. [CAT Scan, MRI, and /or PET Scans]
5. [Infusions and/or Injections done in an Outpatient Health Care facility or Doctor's office]
6. [Miscellaneous Outpatient services], [including Radiation and Chemotherapy]
7. [Dialysis and Filtration Procedures]

Inpatient Covered Services

1. [Hospital Facility services:
 - Semi-private room and board;
 - Intensive care units;
 - Meals and prescribed diets;
 - X-ray and lab services which are diagnostic or therapeutic and Doctor services;
 - Therapeutic services and supplies;
 - General nursing services;
 - Pharmaceuticals administered while an Inpatient
 - Rehabilitative services.]
2. [Skilled Nursing/Sub-Acute Facility, subject
 - Semi-private room and board;
 - Meals and prescribed diets;
 - X-ray and lab services which are diagnostic or therapeutic and Doctor services;
 - Therapeutic services and supplies;
 - General nursing services].
3. Doctor services:
 - Doctor visits [limited to one (1) visit per day] during Confinement in a Hospital [or Skilled Nursing/Sub-Acute Facility];
 - [Surgeries and related anesthesia;]
 - Medical services including radiology and laboratory services ordered by or provided by a Doctor while Confined.

Surgical Services

Surgical services include both facility and Provider fees associated with any surgery, whether done as an Inpatient, Outpatient or in a Doctor's office. Benefits are paid at the Surgical Services Benefit shown on the Schedule of Benefits

Services include:

- Surgeon and Assistant Surgeon
- Anesthesia
- Facility fees
- Supplies, Drugs, and miscellaneous items used in association with the surgical event

Reproductive Covered Services

1. Maternity Care:

Coverage for maternity care, including Complications of Pregnancy, starts with the date the Covered Person's Coverage becomes effective under the Policy and ends when the Covered Person's Coverage terminates, [unless the Covered Person is Confined in a Hospital [or Skilled Nursing/Sub-Acute facility] on that date. If a Covered Person is Confined on that date, Coverage will terminate when the Covered Person has been discharged. See Extension of Benefits] Benefits for Outpatient maternity services will be paid at the Reproductive services Benefit shown on the Schedule of Benefits and not at the Outpatient Services Benefit level.

The following are Covered Services:

- Forty-eight (48) hours of Inpatient care following a normal delivery and ninety-six (96) hours of Inpatient care following a cesarean delivery, unless after conferring with the mother or a person responsible for the mother or newborn, the Attending Doctor or a certified nurse-midwife who consults with a Doctor, decides to discharge the mother or newborn child sooner. In the event of early discharge, Home Health Care visits may be provided;
 - Pre-natal and post-natal visits to a Doctor. The Policy will not pay for pre-natal visits which occur prior to the date Your Coverage takes effect;
 - Delivery charges;
 - In-Hospital Doctor visits;
 - In-Hospital care for a newborn child, subject to the enrollment and Premium payment requirements;
 - Rooming in for maternity care;
2. [Voluntary sterilization surgery;]
 3. [Elective termination of pregnancy.]

Mental Disorder/Drug Abuse and Alcoholism [not] (including Severe Mental Illness and Serious Emotional Disturbance of a Child) Covered Services

A separate Benefit limit is shown on the Schedule of Benefits for alcoholism Covered Services. Benefits for Outpatient Mental Disorder/Drug Abuse and Outpatient alcoholism services will be paid at the mental health/Drug Abuse/alcoholism Benefit level shown on the Schedule of Benefits and not at the Outpatient services Benefit level.

1. Outpatient Mental Disorder services [not] (including Severe Mental Illness and Serious Emotional Disturbance of a Child):

Outpatient Mental Disorder services provided by a Doctor, Health Care Practitioner, or psychologist. The programs must be approved by the Joint Commission on Accreditation of Health Care Organizations or certified by the State Department of Health or the State Department of Mental Health. The services must be provided in one of the following:

- The Provider's office;
- A Hospital-related program;
- A free-standing unit;
- A day or night treatment unit; or
- A community mental health center;

2. Inpatient Mental Disorder services [not] (including Severe Mental Illness and Serious Emotional Disturbance of a Child):

Inpatient mental disorder care while Confined in a Hospital, [or Skilled Nursing/Sub-Acute Facility], including day treatment and partial hospitalization. Care includes room and board, services and supplies. Inpatient and Outpatient Drug Abuse detoxification:

- Evaluation and medical treatment of acute detoxification;

3. Inpatient and Outpatient Drug Abuse services rendered in a Health Care facility or Doctor's office;

4. Inpatient and Outpatient Alcoholism services:

Alcoholism treatment, including rehabilitation and detoxification, provided by or under the clinical supervision of a Doctor or licensed psychologist. The services must be provided in one of the following:

- The Doctor's or psychologist's office;
- A Hospital;
- A community mental health center or alcoholism treatment facility approved by the Joint Commission on Accreditation of Hospitals or certified by the State Department of Health.

[Urgent Care Covered Services]

[Visits to an Urgent Care Facility for Urgent Care of a Condition.]

Emergency Covered Services

Visits to an Emergency room for stabilization or the initiation of treatment for Emergency Medical Conditions requiring Emergency services.

Other Covered Services

1. Allergy Services:

- Allergy testing – [limited to one (1)- three (3) series] of tests per Policy Year;
- Allergy therapy and injections – includes the administration of allergy therapy, injections, allergy serum, and supplies used for allergy therapy;

2. Radiation Therapy and Chemotherapy;

3. [Rehabilitative Care:

- Inpatient physical therapy, occupational therapy, and restorative speech therapy which is expected to result in significant return of function;
- Outpatient [physical therapy], [occupational,] and [restorative therapy] [or acupuncture] which is expected to result in significant return of function. Each therapy [or acupuncture] treatment is considered one (1) visit.
- [Restorative speech therapy means therapy after an Injury, including stroke, and treatment of a speech abnormality resulting from surgery or trauma to anatomical structures affecting speech.]
- Cardiac and pulmonary therapy which is expected to result in significant return of function.
- [Chiropractic services includes x-rays, office visits, laboratory services, manipulations and modalities (i.e., hot packs, cold packs and ultrasounds, etc.), regardless of Provider type;]
- [Acupuncture therapy: includes office visits, supplies;]

Other Covered Services

4. [Home Health Care services:
 - Doctor-directed Home Health Care follow-up visits provided to a mother or newborn child within seventy-two (72) hours after the mother's or newborn child's early discharge from an Inpatient stay. The Provider conducting the visit must have knowledge and experience in maternity and newborn care.
 - Care provided in a Covered Person's home by a licensed, accredited Home Health Care agency. This care must be under the direction of a Doctor and in conjunction with the need for Skilled Nursing Care and includes:
 - Skilled nursing (L.P.N., R.N.) part-time or intermittent care;
 - Medical social services;
 - Infusion services;
 - Certified nurse assistant services and home health aide services, which provide support in the home under the supervision of an R.N., physical, occupational or speech therapist. A visit of four (4) hours or less by a certified nurse assistant or home health aide will count as one (1) Home Health Care visit. Each visit by any other Home Health Care agency representative will count as one (1) Home Health Care visit;
 - [Physical therapy;]
 - [Occupational therapy;]
 - [Restorative Speech therapy]]
5. [Hospice Care:

Care provided in a Covered Person's home by a licensed, accredited Home Health Care, home Infusion, or Hospice agency, or provided in a Health Care facility. This care must be under the direction of a Doctor in conjunction with the need for Skilled Nursing Care and includes:

 - Skilled nursing (L.P.N., R.N.) part-time or intermittent care;
 - Medical social Services;
 - Nutrition counseling;
 - Physical therapy;
 - Infusion therapy, injectables and related supplies, including site care supplies;
 - Certified nurse assistant services and home health aid services;
 - Occupational therapy
 - Restorative therapy
 - Bereavement services for the family unit for up to the maximum number of days shown on the Schedule of Benefits.
6. [Diabetic Education:

The purpose of Diabetic self-management education is to educate and enable diabetics to understand and practice daily management of diabetic therapy.]
7. [Nutrition Counseling:

Includes services by a Health Care Practitioner for general nutrition, weight loss, a medical Condition or a psychological Condition such as eating disorders including anorexia and bulimia.]
8. [Prosthetic Appliances:

Examples include: prescribed external prosthetic appliances, including artificial limbs and eyes; breast prosthesis following surgery to control breast disease; and prosthetic devices and [installation accessories to restore a method of speaking following a laryngectomy. Coverage includes replacement, repair, fitting and adjustment];]
9. [Foot surgery [and orthotics]: Foot disfigurement includes but is not limited to disfigurement from cerebral palsy, arthritis, polio, spina bifida, diabetes and foot disfigurement caused by accident or developmental disability;]

Other Covered Services

10. [Temporomandibular Joint (TMJ):
 - treatment for the dysfunction of the temporomandibular joints, including surgery of the jaw to correct or treat TMJ, subject to the Benefit limits shown on the Schedule of Benefits
 - Refer to Reconstructive Surgery for other covered surgeries;]
11. [Oral Surgery for Accidental Injuries:

Dental services are limited to immediate care to stabilize Conditions due to accidental Injury and include:

 - Services provided by a dentist within seventy-two (72) hours of accidental Injury to sound natural Teeth;
 - treatment of Injury to jawbone or surrounding tissues;
 - Correction of a non-dental physiological Condition which has resulted in severe functional impairment;]
12. [Testing and treatment of phenylketonuria (PKU), including Formulas and special food products prescribed by and under the supervision of a Doctor. Charges for Formulas or special food products are covered to the extent that the costs of the Formulas and special food products exceed the costs of a normal diet;]
13. [Blood and Body Fluid Needlestick Exposure: Coverage is restricted to academic related exposures only and includes any geographic location, in any medical facility. Coverage includes: lab tests done on the Student and the patient/donor involved in the exposure, Emergency room visits, Doctor visits and medications necessary to treat the exposure.]

Other Covered Services

[Durable Medical Equipment and Medical Supplies:

Durable Medical Equipment eligibility will be based on Medical Necessity. Durable Medical Equipment and medical supplies must be prescribed by a Doctor. [The Review Organization We will review and determine whether the Durable Medical Equipment will be rented or purchased, repaired or replaced.] The Durable Medical Equipment and medical supplies must be designed for repeated use and must be Medically Necessary to:

- Treat a Condition; or
- Improve or restore the functional ability of a malformed body part; or
- Prevent worsening of the Covered Person's Condition.

Durable Medical Equipment and medical supplies include, but are not limited to, the following:

- a. Braces, including necessary adjustments to shoes to accommodate braces (dental braces are excluded);
- b. Mechanical equipment and monitors necessary for the treatment of chronic or acute respiratory failure, (environmental items are excluded);
- c. Manual Hospital-type beds and mattresses;
- d. Canes, crutches, walkers or standard wheelchairs;
- e. Oxygen and equipment for its administration;
- f. Commode items, i.e. - bedside handrails, shower bench;
- g. Electronic larynx and voice prosthesis buttons;
- h. Insulin pumps and all related necessary supplies;
- i. Podiatric devices to prevent or treat diabetes-related complications;
- j. Visual aids, excluding eyewear, to assist the visually impaired with proper dosing of insulin;
- k. The following equipment and supplies for the management and treatment of diabetes. Benefits will not be paid under this Durable Medical Equipment Benefit if this Policy has retail and/or mail service prescription drug Coverage:
 - Blood glucose testing device, including those designed to assist the visually impaired (one (1) every three (3) years);
 - Blood glucose testing strips;
 - Ketone urine testing strips;
 - Lancets and lancet puncture devices;
 - Pen delivery systems for the administration of insulin;
 - Insulin syringes;
- l. Ostomy/ileostomy supplies;
- m. Special pressure pads;
- n. Medical elastic stockings (limited to two (2) per year);
- o. Pumps and supplies to deliver an external product;
- p. Prosthetic Bra and/or Q-Breast insert (limited to two (2) per year); and
- q. Wigs as a result of cancer Therapy (limit one (1) per year).]

14. [Reconstructive Surgery:

- [Reconstructive Surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or diseases to either improve function or to create a normal appearance];
- Reconstructive Surgery to restore or correct a Loss of function resulting from surgery, or trauma, infection or other disease, including initial implantation of prosthesis, such as following cancer surgery;
- Reconstructive breast surgery following a mastectomy for breast cancer. Coverage is provided for all complications from a mastectomy, including lymphedema. Surgery and reconstruction of the unaffected breast to produce a symmetrical appearance is also covered when performed as part of the same procedure.
- Orthognathic Surgery.]

Other Covered Services

15. [Emergency Medical Transportation services:
 - Transportation by a licensed ambulance to the nearest Hospital for Emergency Care;
 - Transportation for inter-Health Care facility transfers;
 - Emergency Medical Transportation services through the 911 Emergency response system;]
16. [Eye refractions, performed by a Doctor or optometrist, when used as a diagnostic tool in conjunction with a chronic or acute medical Condition;]
17. [Repair of eye glasses, contact lens or hearing aids when required as a direct result of an Injury]
18. [General anesthesia and associated facility charges for dental procedures rendered in a Hospital or surgery center setting for the following:
 - [Covered Persons who are age [seven (7) or less;]
 - Covered Persons who are developmentally disabled;
 - Covered Persons whose health is compromised and for whom general anesthesia is Medically Necessary.

Benefits will not be paid for the dental procedure itself, including the dentist's professional fee;]

19. [Dialysis (hemodialysis and peritoneal dialysis) and filtration procedures for acute or chronic renal failure, including administration and supply expenses.]
20. [Repatriation of Remains Benefit:

If the Covered Person dies while Insured under the Policy, We will pay for the Reasonable and Customary Charge incurred for embalming, and/or cremation and returning the body to his place of residence in his home country or country of regular domicile, subject to the Coinsurance, Deductible, Copayment, maximums and limits as stated in the Schedule of Benefits and subject to the Exclusions and Limitations provision. Expenses for repatriation of remains require the Policyholder's and Our prior approval. If you are a United States citizen, your home country is the United States.] [This benefit does not include the transportation expense of anyone accompanying the body, visitation expenses or funeral expenses.]
21. [Medical Evacuation Benefit:

If the Insured Student cannot continue his academic program because he sustains an Injury or becomes ill while Insured under the Policy or if an Insured Dependent sustains an Injury or becomes ill, we will pay for the Reasonable and Customary Charges incurred for a medical evacuation of the Covered Person to or back to the Covered Person's home [state,] country or country of regular domicile, subject to the Coinsurance, Deductible, Copayment, maximums and limits as stated in the Schedule of Benefits and subject to the Exclusions and Limitations provisions. However, the Pre-existing Conditions Limitation does not apply to this provision. No payment will be made under this provision unless the evacuation follows a Hospital Confinement of at least [three (3)- seven (7)] days. Before we make any payment, we require written certification by the Doctor that the evacuation is Medically Necessary. Any expense for medical evacuation requires Our prior approval and coordination. Once evacuation is made outside the country, Coverage terminates.] [This benefit does not include the transportation expense of anyone accompanying the body, visitation expenses or funeral expenses.]

Other Covered Services

22. Prescription Drugs

A written prescription by a Doctor or Health Care Practitioner is required. Benefits for expenses Incurred are subject to the applicable Copayments or Coinsurance amounts [and are also subject to the Policy Year Deductible,] if applicable], as shown on the Schedule of Benefits. [Prescription Copayment amounts, if any, do not apply to the Deductible.] A Copayment or Coinsurance is required each time a thirty (30) day supply prescription drug is dispensed. [A maximum of [thirty (30) or sixty (60)] day supply can be dispensed at any one (1) time prescriptions will be dispensed based on Our guidelines.]

The following drugs and medicines are eligible for Benefits:

- Federal Legend Drugs;
- Specialty Drugs - Benefits are payable under the Non-Formulary Brand Benefit;
- Injectable/insulin, prescriptive medications for the treatment of diabetes, Glucagon and the following equipment and supplies for the management and treatment of diabetes. [For the following, Benefits will not be paid under the Durable Medical Equipment Benefit]:
 - a. Blood glucose testing device, including those designed to assist the visually impaired (one (1) every three (3) years)
 - b. Blood glucose testing strips
 - c. Ketone urine testing strips
 - d. Lancets and lancet puncture devices
 - e. Pen delivery systems for the administration of insulin
 - f. Insulin syringes]
- Compounded drugs of which at least one (1) ingredient is a Federal Legend Drug;
- Any other drug which due to state law may only be dispensed when prescribed by a Provider;
- [Smoking deterrent prescription medications;]
- [Prescription contraceptives which have been approved by the FDA;]
- Prescribed drugs and Medically Necessary services needed to administer the drug which are otherwise eligible for Benefits, if the drug is:
 - a. Approved by the U.S. Food and Drug Administration (FDA); and
 - b. Recognized as safe and effective for the treatment of a Condition by one (1) or more of the Standard Medical Reference Compendia or in the Medical Literature, even if the prescribed drug has not been approved by the FDA for the treatment of that specific Condition; and
 - c. Prescribed for the treatment of a Life-Threatening Condition; or
 - d. Prescribed for the treatment of a Chronic and seriously debilitating Condition, is Medically Necessary to treat that Condition, and is on Our formulary.

In this section:

“Life-threatening” means either or both of the following:

- a. Diseases or Conditions where the likelihood of death is high unless the course of the disease is interrupted.
- b. Diseases or Conditions with potentially fatal outcomes, where the end point of clinical intervention is survival.

“Chronic and seriously debilitating” means diseases or Conditions that require ongoing treatment to maintain remission or prevent deterioration and cause significant long-term morbidity.

“Standard Medical Reference Compendia” means the following publications:

- a. The “AMA Drug Evaluations”, published by the American Medical Association;
- b. The “American Hospital Formulary Service (AHFS) Drug Information”, published by the American Society of Health System Pharmacists; or
- c. “Drug Information for the Health Care Provider”, published by the U.S. Pharmacopoeia Convention.

“Medical Literature” means all of the following:

- a. Two (2) (articles from major peer-reviewed professional medical journals which have recognized, based on scientific or medical criteria, the drug’s safety and effectiveness for treatment of the Condition for which it has been prescribed; and
- b. No article from a major peer-reviewed professional medical journal has concluded, based on scientific or medical criteria, that the drug is unsafe or ineffective or that the drug’s safety and effectiveness cannot be determined for the treatment of the Condition for which it has been prescribed; and
- c. Each article meets the uniform requirements for manuscripts submitted to biomedical journals established by the international committee of medical journal editors or is published in a journal specified by the United States Department of Health and Human Services pursuant to federal law, as accepted peer-reviewed medical literature.

“Brand Name” means a trademark name of a drug appearing on the package label.

“Federal Legend Drugs” means any drug or medicine whose label must bear the legend “CAUTION: Federal Law Prohibits Dispensing without a Prescription” or similar warning.

“Formulary” means a list of Brand Name Drugs that are available at a lower cost than Non-Formulary Brand Drugs.

“Formulary Brand Drug” means a Brand Name drug that is on the Formulary.

“Generic Drug” means a non-brand name drug, which is a pharmaceutical equivalent to a Brand Name drug, sold at a lower cost.

“Non-Formulary Brand Drug” means a Brand Name drug that is not on the Formulary.

RETAIL PRESCRIPTION DRUGS

You must show Your Identification Card to the pharmacist. [The dispensing maximum per prescription or refill cannot exceed a thirty (30) day supply.] A copay must be paid for each thirty (30) day supply of a prescription.

Normally there are no claims to file. If you forget Your Identification Card, You may be asked to file a claim form for reimbursement. Save Your receipt and call Our customer service department to request a form.

[MAIL SERVICE PRESCRIPTION DRUGS]

Under the Mail Service Prescription Drug program, Prescription Drugs, as described above, may be ordered by mail through Our pharmacy Benefits manager. There is no Out-of-Network mail service prescription drug Coverage. The Copayment and/or Coinsurance amounts, whichever applies, shown on the Schedule of Benefits must be sent with each prescription or refill. You may call Our customer service department for determination of the dollar amount for each prescription or refill. The dispensing maximum per prescription or refill cannot exceed a [thirty (30), sixty (60), ninety (90)] day supply. [Thirty (30) days prior to your Coverage termination date, You are restricted to a [thirty (30), sixty (60), ninety (90)] day refill amount.] If You have mail service prescription drug Coverage, the pharmacy Benefits manager will send You information on how to order Drugs through the mail.

[ACCIDENTAL DEATH [AND DISMEMBERMENT] BENEFIT]

[Insured Student Only]

If the Eligible Person, within [ninety (90)] [one hundred eighty (180)] [three hundred sixty-five (365)] days from the date of an Accident which occurs while Coverage is in force, dies as the result of Injury from such Accident, We will pay the Eligible Person's beneficiary the amount for Loss of life as shown on the Schedule of Benefits. If the Eligible Person, within [ninety (90)] [one hundred eighty (180)] [three hundred sixty-five (365)] from the date of an Accident, which occurs while Coverage is in force, suffers dismemberment as the result of Injury from such Accident, We will pay the Eligible Person the amount set opposite such Loss, as shown on the Schedule of Benefits. If more than one (1) such Loss is sustained as the result of one (1) Accident, we will pay only one (1) amount the largest to which the Eligible Person or his or her beneficiary would be entitled.

[Any benefit payable under this part will be in addition to any benefit otherwise payable under this Policy.]

[Loss of hand or foot means Loss by severance at or above the wrist or ankle joint. Loss of sight must be entire and irrecoverable. [Loss of a thumb and index fingers means Loss by severance at or above the metacarpophalangeal joints, which are the joints between the fingers and the hand.] Any benefit payable under this part will be in addition to any benefit otherwise payable under this Policy.]

This benefit is subject to all the terms, Conditions and exclusions of this Policy.]

[ACCIDENTAL DEATH [AND DISMEMBERMENT] BENEFIT EXCLUSIONS]

These exclusions are in addition to the General Exclusions. No Benefits are payable for any Loss caused by:

- [Bodily or mental infirmity.]
- [Ptomaine or bacterial infections except:
 - a. Infections which occur simultaneously with or through a cut or wound sustained as the direct result of an Injury, independent of any other cause; and
 - b. The accidental ingestion of a contaminated substance.]
- [Medical or surgical treatment, except Losses that result directly from surgical operations made necessary solely by Injury which is the direct result of an Accident, independent of disease or bodily infirmity or any other cause, and performed within three (3) months of the Accident.]
- [Travel, or flight in or descent from any kind of aircraft unless:
 - a. [As a fare paying passenger on a regularly scheduled flight; or]
 - b. [As a passenger on an official flight of the Military Airlift Command of the United States or similar air transport services of other countries.]]
- [War or any act of war, declared or undeclared.]
- [Being under the influence of alcohol or any drug unless administered and taken as prescribed by a Doctor.]
- [Any accident or occurrence arising out of or in the course of employment.]
- [Participation in an attempt to commit an assault or felony, or participation in a riot.]
- [Suicide or intentionally self-inflicted Injury while sane or insane.]
- [Sickness or its medical or surgical treatment, including diagnosis [; or hernia].]
- [Bacterial infection, except through a wound accidentally sustained.]
- [Voluntary gas inhalation or poison voluntarily taken, administered or inhaled.]
- [Riding or driving as a professional in any kind of race for prize money or profit.]
- [Practicing for, participating in, or traveling as a team member to and from interscholastic, intercollegiate, club, professional and semiprofessional sports, racing or speed contests, scuba diving, skin diving or sky diving, or mountaineering (where ropes or guides are customarily used).]]

[ACCIDENTAL DEATH [AND DISMEMBERMENT] BENEFICIARY INFORMATION]

The Eligible Person's beneficiary is the person or persons who will receive his or her Accidental Death [and Dismemberment] Benefit if the Eligible Person dies.

The Eligible Person will be required to name a beneficiary when he or she enrolls. The Covered Person may later change his or her beneficiary. This change must be made on forms We provide and must be received in our home office. Any change will be effective on the date he or she signs proper forms. We will not be responsible for a change received after his or her claim has been paid. When the beneficiary is changed, any previous choice of beneficiary will be void.

More than one (1) beneficiary may be named. We will pay the amount the Eligible Person specifies for each person. If he or she does not specify amounts, we will divide the benefit equally. If one (1) of the beneficiaries dies before the Covered Person dies, We will divide the benefit equally among the others, unless the Covered Person specifies otherwise.

If the Eligible Person fails to name a beneficiary or if there is no beneficiary surviving when the Covered Person dies, We will, at our option, pay in successive order, the spouse, children, parents, brothers, sisters, or the Eligible Person's estate.

GENERAL EXCLUSIONS AND LIMITATIONS

Unless specifically included, no Benefits will be paid for: a) Loss or expense caused by, contributed to, or resulting from; b) treatment, services, or supplies for, at, or related to:

1. [Eyeglasses, contact lenses, including but not limited to routine eye refractions, eye exams [except as in the case of Injury]. Orthoptic Therapy, visual training or radial keratotomy or similar surgical procedures to correct vision, except as provided herein;]
2. [Hearing Screenings or hearing examinations or hearing aids and the fitting or repairing of hearing aids; [except in the case of Accident or Injury]
3. [Vaccinations, inoculations and preventive shots: a) required for travel; b) required for employment; c) provided as wellness or prevention other than well baby/child [or specifically listed immunizations provided herein]]
4. [Treatment (other than surgery) of chronic Conditions of the foot including, but not limited to, weak or fallen arches, flat or pronated foot ,subluxations of the foot, foot strain, care of corns, calluses, toenails or bunions, any type of massage procedure on or to the foot, corrective shoes, shoe inserts and orthotics;]
5. [Cosmetic surgery, Plastic surgery, resulting complications, consequences and after effects or other services and supplies that We determine to be furnished primarily to improve appearance rather than a physical function or control of organic disease [except as provided herein] [or for treatment of an Injury that is covered under the Policy]. Improvements of physical function does not include improvement of self-esteem, personal concept of body image, or relief of social, emotional, or psychological distress. Procedures not covered include, but are not limited to: face lifts, rhinoplasty, sagging eyelids, prominent ears, skin scars, baldness, and correction of breast size, asymmetry or shape by means of reduction, augmentation, or breast implants (except for correction or deformity resulting from mastectomies or lymph node dissections);]
6. [[Sexual reassignment surgery] [or any treatment of gender identity disorders;]]
7. [Treatment, service, or supply which is not Medically Necessary as determined by Nationwide Life Insurance for the diagnosis, care or treatment of the Sickness or Injury involved. [This applies even if they are prescribed, recommended or approved by the Student Health Center or by the person's Attending Doctor or dentist]
8. [Treatments which are considered to be unsafe, Experimental, or Investigational by the American Medical Association (AMA), and resulting complications. Upon written request, claims denied under this provision may be reviewed by an independent medical review entity if You or Your Dependent has a terminal Condition that , according to the health care Provider's current diagnosis, has a high probability of causing death within [two years] from the date of the request for medical review.]
9. [Custodial Care;]
10. [Treatment on or to the Teeth or gums (except as provided herein);]
11. [TMJ]
12. [Injury sustained while (a) participating in any [intramural], [intercollegiate], [professional], [semi-professional] or [club sport, contest, or competition]; (b) traveling to or from such sport, contest, or competition as a participant; or (c) while participating in any practice or Conditioning program for such sport, contest, or competition;]

13. [For an Injury sustained by reason of a motor vehicle accident to the extent that Benefits are paid or payable by any other valid and collectible insurance whether or not claim is made for such Benefits;
For Injury resulting from travel in or upon a [snowmobile], [ATV (all terrain or similar type two or three wheeled vehicle and/or off –road four wheeled motorized vehicles,] [personal watercraft,] [parachuting,] [hang gliding,] [skydiving,] [parasailing,] [scuba diving,] [skin diving,] [speed contests,] or [bungee jumping;]]
14. [Injury occurring in consequence of riding or otherwise being in any vehicle or device of aerial navigation, except as a fare-paying passenger on a regularly scheduled flight of a commercial airline;]
15. [Travel in or upon motor vehicles not primarily designed and licensed for use on public streets or highways;]
16. [Reproductive/Infertility services including but not limited to: fertility tests, infertility (male or female) including any services or supplies rendered for the purpose or with the intent of inducing conception except as specifically provided in this Policy. Examples of fertilization procedures are ovulation induction procedures, in vitro fertilization, embryo transfer or similar procedures that augment or enhance your reproductive ability; artificial insemination; premarital examination; impotence, organic or otherwise; sterilization or sterilization reversal; vasectomy;]
17. [Routine newborn, infant care, well baby nursery and related Doctor charges including circumcision and congenital Conditions, except as specifically provided for in this Policy for newborn or adopted infants;]
18. [Pregnancy that results under a Surrogate Parenting Agreement;]
19. [Elective termination of pregnancy including the morning after pill, plan B;]
20. [Hospital Confinement or any other services or treatment:
That You or Your Dependent(s) are not legally obligated to pay; or
 - a. For which no charge is made.]
21. [Services provided normally without charge by the health service of the Policyholder, or services covered or provided by a Student health fee;]
22. [Treatment in a government Hospital, unless there is a legal obligation for the Covered Person to pay for such treatment;]
23. [Any services of a Doctor, Nurse, or Health Care Practitioner who lives with You or Your Dependent(s) or who is related to You or Your Dependent(s) by blood or marriage.]
24. [Expense covered by any other valid and collectible insurance to the extent that Benefits are payable under any other valid and collectible insurance whether or not a claim is made for such Benefits;]
25. [Services received before the Insured's Effective Date [or during an Inpatient stay that began before the Insured's Effective Date.] Services received after the Insured's Coverage ends, except as specifically provided under the Extension of Benefits provision;
 - a. Under the Prescription Drug Benefit, when included, any drug or medicine:
 - b. Obtainable Over the Counter (OTC);
 - c. [Containing nicotine or other smoking deterrent medication;]
 - d. For the treatment of alopecia (hair Loss) or hirsutism (hair removal);
 - e. For the purpose of weight control;
 - f. Anabolic steroids used for body building;
 - g. [For the treatment of infertility;]
 - h. [Birth control of any means], [including plan B or Morning After Pill]
 - i. Sexual enhancement Drugs;
 - j. Cosmetic, including but not limited to, the removal of wrinkles or other natural skin blemishes due to aging or physical maturation, or treatment of acne [except as specifically provided in this Policy];
 - k. [treatment of nail (toe or finger) fungus;]
 - l. Refills in excess of the number specified or dispensed after one (1) year of date of the prescription;
 - m. For an amount that exceeds a [20,30,40,60,90] day supply

- n. Drugs labeled, "Caution – limited by federal law to Investigational use" or Experimental Drugs;
 - o. Purchased after Coverage under the Policy terminates;
 - p. Consumed or administered at the place where it is dispensed;
 - q. If the FDA determines that the drug is:
 - Contraindicated for the treatment of the Condition for which the drug was prescribed; or
 - Experimental for any reason.]
26. [Drugs and medicines when not confined in a Hospital or Skilled Nursing Facility as an Inpatient, except as provided in the Prescription Drug benefit;]
 27. [Vitamins, minerals, food supplements, herbs, herbal Formulas, or home remedies; except as herein provided.]
 28. [Addictions such as [nicotine addiction], caffeine addiction and non-chemicals addictions such as gambling, sexual, spending, shopping, working and religious; and codependency;]
 29. [Testing for [Learning disabilities] or other educational purposes including, but not limited to school placement or progress, psychological or intelligence testing,]
 30. [Vocational recreation, art, dance, poetry, music, or other similar-type therapies, including regression therapy; personal enhancement or self-actualization Therapy;]
 31. [Treatments which do not meet the national standards for mental health professional practice; telephonic consultation, methadone maintenance or treatment; and facilities or homes that provide twenty-four (24) hour non-medical residential care or day care.]
 32. [For Injury caused by, contributed to or resulting from the Covered Person's use of alcohol, illegal drug or use of legal medicines that are not taken in the dosage or for the purposed as prescribed by the Covered Person's Doctor;]
 33. [Injuries sustained as a result of suicide or any attempt at suicide, including drug overdose or intentional/unintentional self-inflicted Injury or any attempt at intentional/unintentional self-inflicted Injury;]
 34. [Services for the treatment of any Injury or Illness incurred while committing or attempting to commit a felony; or while taking part in an insurrection or riot; [or fighting, except in self-defense;]
 35. [Any and all over the counter smoking cessation and treatment of nicotine addiction products;]
 36. [Modifications made to dwellings, property, or automobiles such as ramps, elevators, stair lifts, swimming pools, spas, air Conditioners or air-filtering systems, equipment that may increase the value of the residence, or car hand controls, whether or not their installation is for purposes of providing therapy or easy access, or are portable to other locations;]
 37. [Obesity treatment: Services and associated expenses for the treatment of obesity and any resulting complications, consequences and after effects of treatment that involves surgery and any other associated expenses, including, but not limited to:
 - Gastric or intestinal bypasses;
 - Gastric balloons;
 - Stomach stapling;
 - Wiring of the jaw;
 - Panniculectomy;
 - Appetite suppressants;
 - Surgery for removal of excess skin or fat;]
 38. [Injury or Sickness for which Benefits are paid or payable under any workers' compensation or occupation disease law or act, or similar legislation;]
 39. War or any act of war, declared or undeclared; or while in the armed forces of any country;

- 40. [Habilitative physical therapy and occupational or speech therapy;]
- 41. [Nutrition counseling services, genetic counseling and genetic studies;]
- 42. [General fitness, exercise programs, health club memberships and weight loss programs. Exercise machinery or equipment, including but not limited to treadmill, stair steps, trampolines, weights, sports equipment, support braces used primarily for use during any sport or in the course of employment, any equipment obtainable without a Doctor's prescription;]
- 43. [Solid organs, including but not limited to: autologous and allogenic bone marrow transplants, autologous and allogenic stem cell transplants, including non-human organs or bone marrow; Anything caused by, contributed to, or resulting from an organ transplant, including complications thereof;]
- 44. [Treatment received outside of the United States of America, except when Medically Necessary for an Emergency Confinement in a Hospital;]
- 45. [MP Electronic Beam (EBCT) Scan, or "Ultra Fast CT";]
- 46. [Any benefit not listed in this Policy;]

[PRE-EXISTING CONDITIONS LIMITATION]

[There is no Coverage for Pre-existing Conditions unless the Covered Person has had [three (3), six (6), twelve (12)] months of Continuous Coverage.

The Covered Person must provide us proof of prior Creditable Coverage.

Pre existing Conditions in excess of \$[500-2,500] are not covered for the first [three (3), six (6), twelve (12)] months following the Covered Person's Effective Date of Coverage under the Policy.

This limitation will not apply if, during the period immediately preceding the Covered Person's Effective Date of Coverage under this Policy, the Covered Person was covered under prior Creditable Coverage for six (6) consecutive months. Prior Creditable Coverage of less than six (6) months will be credited toward satisfying the Pre-existing Condition limitation. This waiver of Pre-existing Conditions will apply only if the Covered Person becomes eligible and applies for Coverage within sixty-three (63) days of termination of his or her prior Coverage.

[Pregnancy, including Complications of Pregnancy maternity care and genetic disorders, shall not be considered a Pre-existing Condition under the Policy.]

[Pregnancy existing on the Covered Person's Effective Date of Coverage will be considered a pre existing Condition.]

Continuous Coverage: The period of time that a Covered Person is continuously Insured under this Policy and/or any prior Creditable Coverage with no greater than a sixty-three (63) day lapse between the Effective Date of Coverage under this Policy and the termination of prior Creditable Coverage.]

[PRE-CERTIFICATION PROCESS]

[The Schedule of Benefits identifies medical Covered Services which must be Pre-Certified by the Review Organization. Advising the Review Organization before You receive such medical Covered Services allows the Review Organization to determine Medical Necessity and Medical Appropriateness. Medical care that is not necessary and appropriate adds to the cost of care and exposes You to unnecessary risk.

You are responsible for calling the Review Organization at the phone number found on the back of your ID card and starting the Pre-Certification process. For Inpatient services, the call [must] [should] be made [at least five (5) working days] prior to Hospital Confinement. In the case of an Emergency, the call must take place [within two (2) working days of admission] [or] [as soon as reasonably possible].

Pre-Certification is not required for Emergency or Urgent Care.

[Failure to comply with the Pre-Certification process requirements [will] [may] result in a Pre-Certification penalty. Such penalty amount is payable even though Deductible and Coinsurance Maximum Limit amounts have been met. The Pre-Certification penalty is listed in the Schedule of Benefits.]

Your Doctor will be notified of the Review Organization's decision as follows:

- For elective (*non-Emergency*) admissions to a Health Care Facility, the Review Organization will notify Your Doctor and the Health Care Facility by telephone and/or in writing of the number of Inpatient days, if any, approved;
- For Confinement in a Health Care Facility *longer than* the originally approved number of days, Your treating Doctor or the Health Care Facility must contact the Review Organization before the last approved day. The Review Organization will review the request for continued stay to determine Medical Necessity and notify the Doctor or the Health Care Facility of its decision in writing or by telephone;
- [For any other Covered Services requiring Pre-Certification (identified in the schedule of Benefits), the Review Organization will contact the Provider in writing or by telephone regarding its decision;]

Our Review Organization agent will make this determination within seventy-two (72) hours for an urgent request and four (4) business days for non urgent requests following receipt of all necessary information for review. Notice of an adverse determination made by the Review Organization agent will be in writing and will include:

- The reasons for the adverse determination including the clinical rationale, if any.
- Instructions on how to initiate standard or urgent appeal.
- Notice of the availability, upon request of the Covered Person, or the Covered Person's designee, of the clinical review criteria relied upon to make the adverse determination. This notice will specify what, if any additional necessary information must be provided to, or obtained by, the Review Organization Agent in order to render a decision on any requested appeal.

Failure by the Review Organization agent to make a determination within the time periods prescribed shall be deemed to be an adverse determination subject to appeal.

If You have questions about Your Pre-Certification status, You should contact Your Provider.]

[PRE-ADMISSION NOTIFICATION]

Pre-Notification of Medical Non-Emergency Hospitalizations:

The Covered Person, Doctor or Hospital should call the toll free telephone number on the back of the Identification Card at least five (5) working days prior to the planned admission.

Notification of Medical Emergency Admissions:

The Covered Person, Doctor, Covered Person's representative, or Hospital should call the toll free telephone number on the back of the ID card within two (2) working days of the admission to provide notification of any admission due to Medical Emergency.

[Important: Failure to follow the notification procedure will not affect Benefits otherwise payable under the Policy. However, failure to follow the pre-notification procedures will result in the Pre-Notification penalty listed in the Schedule of Benefits. Pre-notification is not a guarantee that Benefits will be paid.]

[PREFERRED PROVIDER BENEFIT]

We encourage Covered Persons to use Preferred Providers by providing benefit incentives when Preferred Providers are used.

In the event of an Emergency Admission, services rendered by any Hospital due to and within the first twenty-four (24) hours after the onset of the Emergency are covered as if the service had been provided by a Preferred Hospital.

In the case of a Medical Emergency, if outside of a [twenty-five (25)-fifty (50)]-mile radius of the [Student Health Center (SHC)] and/or [In-Network Provider] and an Out-of-Network Provider are used, the In-Network percentage in the Schedule of Benefits will be applied.

A Covered Person is not required to seek treatment from a Preferred Provider. Each Covered Person is free to elect the services of a Provider and Benefits payable will be made in accordance with the terms and Conditions of this benefit.

We do not make any representation or warranty as to the medical competence or ability of a Preferred Provider or to their respective staff or Doctors. We shall not have any liability or responsibility, direct, indirect, vicarious or otherwise, for any actions or inactions, whether negligent or otherwise, of the Preferred Provider, their staff or Doctors.

Out-of-Network Provider: Any Hospital or Doctor that is not a member of the Preferred Provider network arrangement that has contracted with Us.

Preferred Provider: Any Hospital or Doctor that has contracted with Us to provide services, as described in this Policy, through a Preferred Provider network arrangement, to be reimbursed at discounted fees.

[If you are undergoing an active course of treatment with a preferred Provider for an acute Condition, a serious chronic Condition, a pregnancy, a terminal Illness, the care of a newborn child between birth and age thirty-six (36) months or performance of a surgery or other procedure that has been recommended and documented by the preferred Provider to occur within one hundred eighty (180) days of the Preferred Provider's contract termination date, you may request continuation of treatment by such Preferred Provider in the event the Preferred Provider's contract has terminated with the Preferred Provider Organization.

- An acute Condition is a medical Condition that involves a sudden onset of symptoms due to an Illness, Injury, or other medical problem that requires prompt medical attention and that has a limited duration. Completion of Covered Services shall be provided for the duration of the acute Condition or until the Covered Person's Coverage terminated, whichever occurs first.
- A serious chronic Condition is a medical Condition due to a disease, Illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration. Completion of Covered Services shall be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another Provider, as determined by the health insurer in consultation with the Insured and the terminated preferred Provider and consistent with good professional practice. Completion of Covered Services under this paragraph shall not exceed twelve (12) months from the preferred Provider's contract termination date or until the Covered Person's Coverage terminated, whichever occurs first.
- A pregnancy is the three trimesters of pregnancy and the immediate postpartum period. Completion of Covered Services shall be provided for the duration of the pregnancy or until the Covered Person's Coverage terminated, whichever occurs first.
- A terminal Illness is an incurable or irreversible Condition that has a high probability of causing death within one or two years or less. Completion of Covered Services shall be provided for the duration of a terminal Illness or until the Covered Person's Coverage terminated, whichever occurs first.
- The care of a newborn child between birth and age thirty-six (36) months will not exceed twelve (12) months from the preferred Provider's contract termination date.]

[STUDENT HEALTH SERVICES REFERRAL]

The Student must first seek services of the Student Health Center (SHC). If the SHC cannot provide the service needed, the Student must obtain an initial referral that verifies that the services were not available at the SHC. The Student is then free to seek services without penalty with a Provider outside of the SHC. Expenses incurred for treatment rendered outside of the SHC for which no referral is obtained will be excluded from Coverage.

A SHC referral for outside care is necessary except under the following Conditions:

- Medical Emergency;
- When the SHC is closed [for four (4) or more continuous days] due to official holidays or breaks;
- Medical care received when the Student is more than [twenty five (25)- fifty (50)] miles from campus;
- Medical care obtained when the Student is no longer able to use the SHC due to change in Student status;
or
- Maternity.

A written referral from the SHC is required for any follow-up care, with a Provider other than SHC, after Emergency services.

[Each written referral for a Condition is valid for ninety (90) days unless a greater time period is indicated on the referral form.]

A SHC referral does not constitute a guarantee of Benefits when treatment is provided outside the SHC. We reserve the right to determine the Medical Necessity of treatment for services provided outside the SHC.

[Dependents are not eligible to use the SHC, and therefore, are exempt from the SHC referral requirement.]

[COORDINATION OF BENEFITS]

Read this section with care. It applies to all sections of the Policy that pay Benefits for Covered Charges except the Prescription Drug Benefit if it is contained in this Policy.

The intent of this section is to help control Your Premium costs by preventing financial gain by persons Insured under more than one plan. All plans will be taken into account for this section, even plans, which do not have a coordination of Benefits provision.

Benefits received from this Policy are coordinated with Benefits, which the Covered Person may receive from certain other plans. The Covered Person is urged to file any claims as early as possible with all insurance companies under which he or she has health Coverage. This will help Us to provide the Maximum Benefit due as soon as possible.

The total benefit received from all plans may not exceed 100% of Allowable expenses.

DEFINITIONS APPLICABLE TO COORDINATION OF BENEFITS SECTION:

"Covered Person" means the person for whom a claim is being made.

"plan" means any plan that provides Benefits or services for or by reason of medical or dental care or treatment. These are:

1. Group, blanket, or franchise insurance Coverage whether Insured or unInsured but not including:
 - A contract covering elementary, junior high, high school and or college Students for accidents only, including athletic injuries, on a twenty-four hour basis or on a "to and from school" basis; or
 - Hospital indemnity Benefits of \$100 per day or less so long as they are the indemnity-type benefit as opposed to the reimbursement-type benefit. (Any amount of Hospital indemnity Benefits of either type which exceed \$100 per day will be included); or
2. Group or group-type Coverage through health maintenance organizations, Hospital or medical service organizations, group practice and other prepayment Coverage; or
3. Labor-management trustee plans, union welfare plans and employer or employee Benefit plans; or
4. Any Coverage required or provided by a government except Medicaid; or
5. No-fault vehicle insurance.

"This Policy" means the sections of this Policy that pay Benefits for Covered Charges.

"Allowable expenses" means any needed, reasonable item of expense which is at least partly covered under one of the plans covering the Covered Person.

When Benefits are reduced under the primary plan because the Covered Person did not comply with the plan provisions, the amount of such reduction will not be considered an Allowable expense. However, the secondary plan cannot refuse to pay Benefits because a Health Maintenance Organization (HMO) member has elected to have health care services provided by a non-HMO Provider and the HMO, pursuant to its contract, is not obligated to pay for providing those services. When a plan provides services rather than cash payments, the reasonable cash value of the service will be considered as both an Allowable expense and a Benefit paid.

EFFECT ON BENEFITS:

The Policy Year is the basis for consideration of claims. This provision will be used when the Benefits the Covered Person would receive under this Policy plus those received under all other plans would exceed the total Allowable expense. If the Benefits provided under all plans exceed the Allowable expense, We will reduce our Benefits so that the total is not exceeded. However, if the Covered Person is Insured under another plan containing a co-ordination of Benefits provision, the following rules will be used to determine which plan may reduce Benefits.

1. That plan which insures the Covered Person as an employee (that is, other than as a Dependent) are determined before those of the plan which covers the Covered Person as a Dependent, except that, if the Covered Person is also a Medicare beneficiary, and as a result of the rules established by Title XVIII of the Social Security Act and implementing regulations, Medicare is:
 - Secondary to the plan covering the person as a Dependent; and
 - (Primary to the plan covering the person as other than a Dependent, then the Benefits of the plan covering the person as a Dependent are determined before those of the plan covering that person as other than a Dependent.
2. The Benefits of a plan which insures the Covered Person as a Dependent child of a person whose date of birth, excluding the year of birth, occurs earlier in the calendar year, shall be determined before the Benefits of a plan which covers such person as a Dependent of a person whose date of birth, excluding the year of birth, occurs later in the calendar year. If both such persons have the same date of birth, the Benefits of the plan of the person who has been Insured under his or her plan for the longer period of time shall be determined first. If the other plan does not have the provisions of this paragraph regarding Dependents, which results in the plans not agreeing on the order of Benefits, the rule set forth in the other plan will determine the order of Benefits.

However, if the Covered Person is a Dependent child with separated or divorced parents, Benefits for the child are determined in this order:

- First, the plan of the parent with custody of the Dependent child;
- Then the plan of the spouse of the parent with custody of the Dependent child; and
- Finally the plan of the parent not having custody of the Dependent child.

However, if there is a court decree, which gives financial responsibility to a particular parent for the health care expenses of the child, statements above do not apply. In this case, any other plan, which covers the child as a Dependent may reduce before the plan which, covers the child as a Dependent of the parent with financial responsibility.

3. If a court decree states that the parents share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the Dependent child shall follow the order of Benefits set forth in rule two (2).
4. The Benefits of a plan which covers a person as an employee who is neither laid-off nor retired (or as that employee's Dependent) are determined before those of a plan which covers that person as a laid-off or retired employee (or as that employee's Dependent). If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of Benefits, this rule four (4) is to be ignored.
5. Continuation Coverage. If a person whose Coverage is provided under a right of continuation pursuant to federal law, namely COBRA, or state law, also is covered under another plan, Benefits are determined in the following order:
 - First, the Benefits of the plan covering the person as an employee (or as that employee's Dependent);
 - Second, the Benefits under the continuation of Coverage.If the other plan does not have this rule and if, as a result, the plans do not agree on the order of Benefits, this rule (5) shall be ignored.

6. When none of the rules above determines the order of Benefits, the plan that has Insured the Covered Person for a shorter period of time may reduce Benefits if another plan has Insured that Covered Person for a longer period of time.

If Benefits are reduced under this section and later in the same Policy Year the total Allowable expense exceeds the Benefits paid under all plans, We will pay additional Benefits. These Benefits will not exceed the lesser of:

- The amount of the earlier reduction; or
- The amount which would cause total Benefits under all plans to exceed total Allowable expenses.

If the total amount of benefit is reduced under this section, each benefit will be reduced proportionately and only the reduced amount will be charged against each benefit limit.

RIGHT TO RECEIVE AND RELEASE INFORMATION:

To carry out this provision:

- The Covered Person must furnish to Us any necessary information; and
- We may, without asking for consent, obtain necessary information from any source; and
- We may release information to other plans.

FACILITY OF PAYMENT/RIGHT OF RECOVERY:

If another plan pays an amount that this Policy should have paid, We have the right to pay the benefit to that plan. This ends Our duty for payment of that claim. If this Policy pays an amount that another plan should have paid, We have the right to recover the excess amount from the person or organization to whom it was paid.

CLAIM PROVISIONS

Notice of Claim: Written Notice of Claim must be given to Us or Our authorized representative within [sixty (60), ninety (90)] days after a covered Loss starts, or as soon thereafter as is reasonably possible. Notice should include information sufficient to identify the Covered Person.

Claim Forms: Upon Our receipt of written Notice of Claim, We will furnish to the claimant such forms as are usually furnished by Us for filing Proofs of Loss. If such forms are not furnished within [fifteen (15)- ninety (90)] days after the giving of such notice, the claimant shall be deemed to have complied with the requirements of this Policy as to Proof of Loss upon submitting, within the time fixed in this Policy for filing Proof of Loss, written proof covering the occurrence, the character, and the extent of the Loss for which claim is made.

Proof of Loss: If it is necessary to file a claim, a written claim form must be given to Us within ninety (90) days of such claim. If it was not possible for the claim form to be given within ninety (90) days, We will not deny the claim because of late filing, provided proof was given as soon as reasonably possible. In any case, the claim form must be sent no later than one (1) year from the date of service, unless the Covered Person is legally incapacitated.

Time of Payment of Claims: Benefits payable under this Policy for any Loss, other than Loss for which this Policy provides any periodic payment, will be paid immediately upon, or within thirty (30) days after, receipt of due written proof of such Loss. Subject to due written proof of Loss, all accrued indemnities for Loss for which this Policy provides periodic payment will be paid monthly and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.

[Use if no AD&D benefit]

Payment of Claims: Benefits will be payable to the Covered Person or the medical services Provider if We have received a valid assignment by the Covered Person.

If any indemnity of this Policy shall be payable to the estate of the Covered Person or to a Covered Person who is a minor or otherwise not competent to give a valid release, We may pay such indemnity to his parent, guardian or other person actually supporting him. Any payment made by Us in good faith pursuant to this provision shall fully discharge Us to the extent of such payment.

Subject to any written direction of the Covered Person or of the legal or natural guardian of the Covered Person, if the Covered Person is a minor or otherwise incompetent to make such a direction, all or a portion of any indemnities provided by the Policy as a result of medical, surgical, dental, Hospital or nursing service may, at Our option, and unless We are requested in writing not later than the time for filing Proofs of Loss, be paid directly to the Hospital or person rendering such services; but it is not requested that the services be rendered by a particular Hospital or person.

[Use if AD&D benefit provided]

Payment of Claims: Unless instructed by You otherwise, Benefits payable under this Policy for Loss of life are payable to the first surviving classes of the Covered Person: spouse; child or children; mother or father; sisters or brothers; or estate. All other Benefits will be payable to the Covered Person or the medical services Provider if We have received a valid assignment by the Covered Person.

If any indemnity of this Policy shall be payable to the estate of the Covered Person or to a Covered Person who is a minor or otherwise not competent to give a valid release, We may pay such indemnity to his parent, guardian or other person actually supporting him. Any payment made by Us in good faith pursuant to this provision shall fully discharge Us to the extent of such payment.

Subject to any written direction of the Covered Person or of the legal or natural guardian of the Covered Person, if the Covered Person is a minor or otherwise incompetent to make such a direction, all or a portion of any indemnities provided by the Policy as a result of medical, surgical, dental, Hospital or nursing service may, at Our option, and unless We are requested in writing not later than the time for filing Proofs of Loss, be paid directly to the Hospital or person rendering such services; but it is not requested that the services be rendered by a particular Hospital or person.

Physical Examination and Autopsy: We, at Our own expense, shall have the right and opportunity to examine the Covered Person as it may reasonably require while a claim is pending. We, at Our own expense, may also have the right to make an autopsy in the case of death, where it is not prohibited by law.

Physical Examination: We, at Our own expense, shall have the right and opportunity to examine the Covered Person as it may reasonably require while a claim is pending.

Legal Actions: A legal action may not be brought to recover on this Policy within sixty (60) days after written Proof of Loss has been given as required. No such action may be brought after three (3) years from the time written proof was required to be given.

[MEDICAL NECESSITY and MEDICAL APPROPRIATENESS DETERMINATION]

We reserve the right to review claims and establish standards and criteria to determine if a Covered Service is Medically Necessary and Medically Appropriate. Benefits will be denied by Us for Covered Services that are not Medically Necessary and Medically Appropriate. In the event of such a denial, You will have to pay the entire amount billed by that Provider. You do have the right to appeal any adverse decision as outlined in the Appeals and Compliant Section of this Policy. [You may have the right to an external independent review as outlined in the Appeals and Compliant Section of this Policy.]

Covered Services are Medically Necessary if they are:

- Required to meet the health care needs of the Covered Person; and
- Consistent (in scope, duration, intensity and frequency of treatment) with current scientifically based guidelines of national medical or research organizations or governmental agencies; and
- Consistent with the diagnosis of the Condition; and
- Required for reasons other than the comfort or convenience of the Covered Person or Provider; and
- Of demonstrated medical value and medical effectiveness.

A Covered Service is Medically Appropriate if it is rendered in the most cost-effective manner and type of setting appropriate for the care and treatment of the Condition.

If You have any questions or concerns about whether a particular service, supply, or treatment is Medically Necessary or Medically Appropriate, contact Us.

PREMIUM

Payment of Premium/Due Date: All Premium, charges or fees (hereinafter "Premium") must be paid to Us at Our home office prior to the start of the term for which Coverage is selected. In no event will Coverage become effective prior to the date of enrollment and required Premium are received at our home office or by Our authorized representative.

Returned or Dishonored Payment: If a check in payment for the Premium is dishonored for insufficient funds, a reasonable service charge may be charged to the Policyholder which will not exceed the maximum specified under state law. A dishonored check shall be considered a failure to pay Premium and Coverage shall not take effect.

GENERAL PROVISIONS

Entire Contract; Changes: The Policy, including the Certificate, if any, endorsements and the attached papers, if any, constitutes the entire contract of insurance. No change in the Policy shall be valid until approved by one of Our executive officers and unless such approval is endorsed hereon or attached hereto. No agent has authority to change the Policy or waive any of its provisions.

Failure by Us to enforce any Policy provision shall not waive, modify or render such provision unenforceable at any other time; at any given time; or under any given set of circumstances, whether the circumstances are or are not the same.

We have full, exclusive and discretionary authority to determine all questions arising in connection with the Policy, including its interpretation.

Grace period: A grace period of thirty-one (31) days will be granted for the payment of Premiums accruing after the first Premium, during which grace period the Policy shall continue in force, but the Covered Person shall be liable to Us for the payment of the Premium accruing for the period the Policy continues in force.

Incontestability: All statements made in an application by the Policyholder are, in the absence of fraud, representations and not warranties. No statement shall be used to contest the Policy, the validity of Coverage or reduce Benefits, unless it is in writing, signed by the Policyholder, and a copy of such statement is furnished to the Policyholder.

Non-Participating: The Policy is non-participating. It does not share in Our profits or surplus earnings.

Conformity with State Statutes: If any provision of this Policy is contrary to any law to which it is subject, such provision is hereby amended to conform to the minimum requirements of such law.

Workers' Compensation: This Policy is not in lieu of and does not affect any requirement for Coverage by Workers' Compensation Insurance.

Clerical Error: If a clerical error is made so that an otherwise Eligible Person's Coverage does not become effective, Coverage may be in effect if: (a) the Policyholder makes a written request for Coverage on a form approved by Us ; and (b) any Premium not paid because of the error is paid in full from the Effective Date of Coverage. Company reserves the right to limit retroactive Coverage to two months preceding the date the error was reported.

If a clerical error is made so that the Coverage is in effect for a person who is not eligible, an adjustment will be made to correct the error. Any Premium refund will be reduced by any payment made for claims. If claims paid exceed the Premium refund, the Policyholder shall reimburse Us for the overpayment.

Information and Records: We shall have the right to inspect, at reasonable times, any of the Policyholder's records for the Policy. The Policyholder shall provide Us with information necessary to administer Coverage and set Premium under the Policy. Information is required when an Eligible Person becomes covered, when changes in amounts of Coverage occur, and when a Covered Person's Coverage terminates.

[SUBROGATION AND RECOVERY RIGHTS]

Right of Recovery: If the amount of the payment made by Us is more than We should have paid under this Policy, We may recover the excess from one or more of: (a) The person we have paid; (b) The person for whom We have paid; (c) Insurance companies or any other plan; or (d) other organization. The amount of the payments made includes the reasonable cash value of any benefit provided in the form of services.

Right to Subrogation: If the Insured suffers an Injury or Sickness through the act or omission of another person, and if Benefits are paid under this Policy due to such Injury or Sickness, then We will be entitled to a refund of all Benefits We have paid from such recovery, as permitted by law. The refund of Benefits shall be allowable to the extent the Insured recovers or may recover for the same Injury or Sickness from another plan, including a third party, its insurer, or the Insured's uninsured motorist insurance. Further, We have the right to offset subsequent Benefits payable to the Insured under the Policy against such recovery.

Upon our request, the Insured must complete the required forms and return them to Us or to Our administrator. The Insured must notify Us of any pending or contemplated claims against third parties. The Insured must cooperate fully with Us in asserting a right to recover. The Insured will be personally liable for reimbursement to Us to the extent of any recovery obtained by the Insured from any third party. If it is necessary for Us to institute legal action against the Insured for failure to repay Us, the Insured will be personally liable for all costs of collection, including reasonable attorney's fees.

We may file a lien in an Insured's action against the third party and have a lien upon any recovery that the Insured receives whether by settlement, judgment, or otherwise, and regardless of how such funds are designated. We shall have the right to recovery of the full amount of Benefits paid under the Policy for the Injury or Sickness, and that amount shall be deducted first from any recovery made by the Insured. We will not be responsible for the Insured's attorney's fees or other costs.

Right to Reimbursement: If Benefits are paid under this plan and any person recovers from a third party by settlement, judgment or by operation of primary Coverage, We have a right to recover from that person an amount equal to the amount We paid. However, We will reimburse the Covered Person from any charges on a pro-rata basis for any expense Incurred in securing the settlement, judgment or otherwise.

Limitation to Our Recovery Rights: We may exercise Our Right to Subrogation against third parties unless We are precluded from enforcing such right where a responsible third party has extinguished its liability or has been relieved of liability by contract or operation of law. If We are precluded from exercising Our Right to Subrogation, We may exercise our Right to Reimbursement.

We, in exercising Our Right to Subrogation, will not seek to recover more than We paid under this plan. We, in exercising Our Right to Reimbursement, will not seek to recover more than the amount recovered from a third party.

[EXCESS PROVISION]

[Except for Student Health Center-generated expenses for laboratory and Prescription Drug expenses,]Our liability for medical expense Benefits payable on account of Covered Charges incurred [resulting from Hospital Confinement or surgery] shall be limited to that part of the expense, if any, which is in excess of the total Benefits payable for the same Sickness or Injury, on a provision of service basis or on an expense Incurred basis under any Other Medical Insurance. If Other Medical Insurance provides Benefits on an excess insurance or an excess Coverage basis, [Benefits will be paid first by the insurer or services plan whose Policy or service contract has been in effect for the longer period of time at the date of such Sickness or Injury.] [We will pay a maximum of fifty (50%) of the Benefits otherwise payable.]

[Covered Charges incurred for treatment rendered by the Policyholder's Student Health Service will be administered on a primary basis.]

For purposes of the Policy, a Covered Person's entitlement to Other Medical Insurance will be determined as if the Policy did not exist and shall not depend upon whether timely application for Benefits from Other Medical Insurance is made by or on behalf of the Covered Person.

[Primary Benefit Amount: If a Primary Benefit Amount is shown in the Schedule of Benefits, We will pay the Covered Charges incurred for a Sickness or Injury up to the Primary Benefit Amount. Such Covered Charges will be paid according to the terms of the Policy. Subsequent claims received for the same Sickness or Injury which are in excess of the Primary Benefit Amount, will subject the entire claim to the Excess Provision.]

Other Medical Insurance: Any reimbursement for or recovery of any element of Covered Charges, incurred available from any other source whatsoever, except gifts and donations, but including without limitation:

- Any individual, group, blanket, or franchise Policy of accident, disability or health insurance.
- Any arrangement of Benefits for members of a group, whether Insured or uninsured.
- Any prepaid service arrangement such as Blue Cross or Blue Shield; individual or group practice plans, or health maintenance organizations.
- Any amount payable for Hospital, medical or other health services for accidental bodily Injury arising out of a motor vehicle accident to the extent such Benefits are payable under any medical expense payment provision (by whatever terminology used including such Benefits mandated by law) of any motor vehicle insurance Policy.
- Any amount payable for services or injuries or diseases related to the Covered Person's job to the extent that he actually received Benefits under a Worker's Compensation Law. If the Covered Person enters into a settlement to give up his rights to recover future medical expenses that would have been payable except for that settlement.
- Social Security Disability Benefits, except that Other Medical Insurance shall not include any increase in Social Security Disability Benefits payable to a Covered Person after he becomes disabled while insured hereunder.
- Any Benefits payable under any program provided or sponsored solely or primarily by any governmental agency or subdivision or through operation of law or regulation.
- Any Policy containing Coverage which provides Benefits for medical expenses on a 1st or 3rd party basis.

COMPLAINT AND APPEAL PROCESS

Complaint Resolution

1. Administrative Complaints

Complaints due to the denial of services or payment of a claim must be reported no later than [twelve (12), eighteen (18)] months from the date of service. Most complaints can be resolved by calling, or writing to, Our Customer Service Department. The telephone number and address are on Your Identification Card.

If an informal review does not resolve the reported complaint, You will be notified of Your right to appeal.

2. Quality of Care or Service Complaint

Quality of care complaints will be forwarded to the unit responsible for such investigations immediately upon receipt by Customer Service. We will send You a written acknowledgment within [three (3), five (5), ten (10), fifteen (15)] working days of receipt of the complaint. All quality of care complaints will be investigated and corrective action taken where problems and/or deficiencies are verified.

3. If We cannot provide You with a satisfactory solution to Your complaint, You may file a standard or urgent (if applicable) appeal for internal review by contacting Us at the address or phone number on the back of your ID card or write to or call the Department of Insurance, whose information is located in the Important Notice section of this Policy.

4. If We deny a claim as “not Medically Necessary” and cannot provide You with a satisfactory solution to Your complaint, You may request an Independent Medical Review (IMR) by writing to or calling Us [or the Department of Insurance, whose information is located in the Important Notice section of this Policy].

Internal Appeal Review

1. Standard Appeals

You, an authorized person, or a Provider, with Your consent, may submit a written appeal to Us if Coverage is denied, reduced or terminated. The appeal must be requested no later than [sixty (60), ninety (90), one hundred eighty (180), or three hundred sixty (360)] calendar days from the date of receipt of the denial letter.

The appeals staff will review all of the information. A decision will be made within thirty (30) calendar days of receipt for a Pre-Service Claim Appeal and within [forty (40), sixty (60)] calendar days of receipt for a Post-Service Claim Appeal. This time period may be extended for up to an additional sixty (60) calendar days if additional information is needed. You will be notified in writing of the Appeals Department's decision. If the appeal involves a medical necessity determination, an independent peer reviewer, who is in the same or a similar specialty, as the Provider who will perform or performed the service will review the file.

A Pre-Service Claims Appeal is an appeal of any claim for Benefits under the terms of the Policy, which must be Pre-Certified (in whole or in part) before medical care is obtained.

A Post-Service Claims Appeal is an appeal of a decision to deny or reduce Benefits for claim that has already been incurred.

2. Urgent Appeals

You, an authorized person or a Provider, with Your consent, may request an Urgent Appeal. This request may be verbal or written. A decision will be made within seventy-two (72) hours of receipt for an Urgent Appeal.

An Urgent Appeal is an appeal for which the medical Condition, in the absence of immediate medical attention, may result in serious impairment to bodily functions, serious dysfunction of any bodily organ or part, severe pain that cannot be managed adequately, or places in serious jeopardy the health of an individual, and with respect to a pregnant woman, includes her unborn child.

External Appeal Process

After exhausting the Internal Appeal Process, You, an authorized person or a Provider, with Your consent, may request a review from an external independent entity as described below.

1. Department of Insurance Review - Coverage Decision Denials

If We deny Benefits because the service is not a Covered Service, a review of the Coverage Decision may be requested by contacting the:

Department of Insurance at the address located in the Important Notice section of this Policy.

2. [Independent Medical Review –Medical Necessity Denials

You may request an Independent Medical Review (IMR) of medical necessity denial from the Department of Insurance if You believe that We have improperly denied, modified, or delayed health care services. A medical necessity denial is any health care service eligible for Coverage and payment under the Policy that has been denied, modified, or delayed by Us, in whole or in part, because the health care service is not Medically Necessary.

The IMR process is in addition to any other procedures or remedies that may be available to You. You pay no fees of any kind for IMR. You have the right to provide information in support of the request for IMR. You may contact the Department of Insurance for an IMR application or Customer Service for assistance.]

Eligibility:

The Department of Insurance will review Your application for IMR if it is filed within [one (1), two (2), three (3), four (4), five (5), six (6)] months of any of the following qualifying periods or events. All of the following Conditions must be met:

- a. Your Provider has recommended a health care service as Medically Necessary; or
- b. You have received Urgent Care or Emergency services that a Provider determined was Medically Necessary; or
- c. In the absence of (a) or (b) You have been seen by a Participating Provider for the diagnosis or treatment of the medical Condition for which You seek independent review; and
 - The claim has been denied, modified, or delayed by Us based in whole or in part on a decision that the health care service is not Medically Necessary; and
 - You have filed an appeal with Us and the disputed decision is upheld or the appeal remains unresolved after thirty (30) days. If Your appeal requires expedited review You may bring it immediately to the Department of Insurance's attention. The Department of Insurance may waive the requirement that You follow the appeal process in unusual cases.

If Your case is eligible for an IMR, the dispute will be submitted to an IMR organization that will make an independent determination of whether or not the care is Medically Necessary. You will receive a copy of the assessment made by the independent reviewer. If the IMR determines the service is Medically Necessary, We will provide Benefits for the health care service.

For non-urgent cases, the IMR organization, independent of the Company, and/or designated by the Department of Insurance must provide its determination within thirty (30) days of receipt of Your application and supporting documents. For urgent cases involving an imminent and serious threat to Your health, including, but not limited to, serious pain, the potential Loss of life, limb, or major bodily function, or the immediate and serious deterioration of Your health, the IMR organization must provide its determination within three (3) business days.

Please call Our Customer Service Department at the phone # on the back of your Identification Card if You have any questions or need additional information.]

3. Independent Medical Review (IMR) - Experimental or Investigational Denials

Eligibility:

You may request an Independent Medical Review (IMR) from an organization independent of the Company [or designated by the Department of Insurance] if all of the following criteria are met:

- a. You have a Life Threatening or Seriously Debilitating Condition, as certified by Your Doctor.
 - (i) "Life Threatening" means either or both of the following:
 - Diseases or Conditions where the likelihood of death is high unless the course of the disease is interrupted;
 - Diseases or Conditions with potentially fatal outcomes, where the end point of clinical intervention is survival.
 - (ii) "Seriously Debilitating Condition" means diseases or Conditions that cause major irreversible morbidity.
- b. Your Doctor certifies that one of the following situations applies:
 - standard therapies have not been effective in improving the Condition;
 - standard therapies are not Medically Necessary for You;
 - there is no standard therapy covered under the Policy that will benefit You more than the requested therapy;
- c. Your Doctor has recommended a drug, device, procedure or other therapy that he or she certifies in writing is likely to benefit You more than standard therapies; or You or Your Doctor have requested a therapy that based on two (2) documents from the Medical and Scientific Evidence as defined below, is likely to be more beneficial for You than any available standard therapy.
- d. The Doctor's certification includes a statement of the evidence relied upon when certifying the recommendation. We will not pay for services of a Non-Participating Provider that are not otherwise covered.
- e. You have been denied Benefits/Covered Services for services requested in (2) above, unless Coverage for the specific therapy is excluded by this Policy;
- f. The drug, device, procedure or other therapy would be covered under the Policy if it were not considered to be Experimental or Investigational.

For the purposes of this section, "Medical and Scientific Evidence" means the following sources:

1. Peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff.
2. Peer-reviewed literature, biomedical compendia and other medical literature that meet the criteria of the National Institute of Health's National Library of Medicine for indexing in Index Medicus, Excerpta Medicus (EMBASE), Medline and MEDLARS database Health services Technology Assessment Research (HSTAR).

3. Medical journals recognized by the Secretary of Health and Human services, under Section 1861(t) (2) of the Social Security Act.
4. The following standard reference compendia: The American Hospital Formulary Service-Drug Information, the American Medical Association Drug Evaluation, the American Dental Association Accepted Dental Therapeutics and The United States Pharmacopoeia-Drug Information.
5. Findings, studies or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes, including the Federal Agency for Health Care Policy and Research, National Institutes of Health, National Cancer Institute, National Academy of Sciences, Health Care Financing Administration, Congressional Office of Technology Assessment, and any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health services.
6. Peer-reviewed abstracts accepted for presentation at major medical association meetings.

Requesting an Independent Review:

1. Within five (5) business days of Our decision to deny, delay or modify treatment that is Experimental or Investigational therapy, We will notify You, in writing, and include your appeal rights, which include your right to appeal to the Department of Insurance. [You may request an Independent Medical Review (IMR) by writing to or calling the Department of Insurance, whose information is located in the Important Notice section of this Policy.]
2. The panel of experts, supplied by the Independent Medical Review agency, will complete its review within thirty (30) calendar days of receiving the request for review. If Your Provider certifies, in writing, that an imminent and serious threat to Your health may exist the review will be expedited and completed within three (3) days of the request for the expedited review.
3. The Independent Medical Review panel of experts will provide [the Department of Insurance], the Company, You and Your Doctor with copies of the review upon completion of the review and analysis. [The Department of Insurance will immediately adopt the decision of the Independent Medical Review agency and will issue a written decision to all concerned parties.]

There is no expense to You for the Independent Medical Review.

MANDATED BENEFITS

Newborn Infant Coverage

Coverage for tests for hypothyroidism, phenylketonuria, galactosemia, sickle-cell anemia, and all other disorders of metabolism for which screening is performed by or for the State of Arkansas.

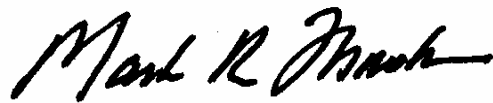
Coverage to pay for routine nursery care and pediatric charges for a well newborn child for up to five (5) full days in a hospital nursery or until the mother is discharged from the hospital following the birth of the child, whichever is the lesser period of time.

IMPORTANT NOTICE

NATIONWIDE LIFE INSURANCE COMPANY
NATIONWIDE SPECIALTY HEALTH DEPARTMENT
[TPA ADDRESS]
[TPA PHONE NUMBER]

If you continue to remain unsatisfied, You may contact the [----- Department of Insurance] with any complaint. To contact the Department of Insurance, You may write or call them at:

Arkansas Insurance Department
[1200 West Third Street
Little Rock, AR 72201-1904
(501) 371-2640]



President

Nationwide Life Insurance Company

Nationwide Life Insurance Company

Home Office: Columbus, Ohio

[UNDERGRADUATE] [GRADUATE] [INTERNATIONAL] BLANKET STUDENT ACCIDENT & SICKNESS BROCHURE

EFFECTIVE DATE: [9/1/2003]

TERMINATION DATE: [9/1/2004]

Premium for each Insured person []

READ YOUR BROCHURE CAREFULLY.

[This coverage excess only. See the excess provision section of the Policy.] Benefits payable under the Policy are subject to reduction if a Covered Person is entitled to Benefits, whether on an indemnity basis or on a provision-of-service basis, for Hospital, medical, dental, or surgical expenses under any other valid and collectible individual, group, or blanket insurance Policy or contract, Hospital or medical service program, or group-practice prepayment plan, except for automobile medical payments insurance.]

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SCHEDULE OF BENEFITS	
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[Your Coverage provides for the utilization of Network Providers in a Preferred Provider Organization (PPO). Certain Benefits are paid at different rates if the service is not provided by a Network Provider. See the Definitions page for the definition of Preferred Provider Organization, Network Provider, Non-Network Provider, In-Network Benefit and Out-of Network Benefit.]

[The Preferred Provider Organization(s) for Your Coverage [is –are]: _____].

[The Review Organization is: []]

[The telephone number of the Review Organization is on Your Identification Card.]

[Student Health Center (SHC) is not available to [Dependents,] [Dependent children,] unless specifically stated.]

[Explanation of Reference Number

¹ [Must be Pre-Certified] [Must be Pre-Notified]]

SCHEDULE OF BENEFITS

[Lifetime Aggregate Maximum*	[10,000-1,000,000]
[Student:]	[10,000-1,000,000]
[Dependent:]	[10,000-1,000,000]

[Including Repatriation and Medical Evacuation]

[Except treatment of an Injury resulting from a motor vehicle accident]	[5,000, 50,000-100,000]
--	-------------------------

[BASIC MEDICAL expense BENEFIT*]

Deductible, Per Sickness or Injury	\$[50, 75, 100]
------------------------------------	-----------------

[The Deductible shall not apply:

- To covered x-ray services performed at the Student Health Center;
- When referred to one of the foregoing facilities by the Policyholder's Student Health Center;
- To covered Outpatient Physiotherapy rendered for treatment of Sickness at the Policyholder's Physical Therapy Health Clinic; or
- Outpatient Prescription Drugs when prescribed and filled at the Policyholder's Student Health Center]

Insured Percent	80% up to \$[2,000 - 5,000] then 100% up to the Major Medical Aggregate Maximum Amount
------------------------	--

Basic Aggregate Maximum Amount Per Sickness or Injury	\$[25,000 to \$250,000]
--	-------------------------

Attention: If an Injury or Sickness first occurs during a Policy Year in which You select the Basic Medical Benefit plan, Covered Charges related to that Injury or Sickness will be limited to the maximum lifetime benefit amount set forth in the Basic Medical Benefit plan. This limitation will continue to apply even if You select the Enhanced Medical Benefit plan in subsequent Policy Years.

[ENHANCED MEDICAL expense BENEFIT*]

Deductible, Per Sickness or Injury	\$[50, 75, 100]
------------------------------------	-----------------

[The Deductible shall not apply:

- To covered x-ray services performed at the Policyholder's Student Health service;
- When referred to one of the foregoing facilities by the Policyholder's Student Health Center;
- To covered Outpatient Physiotherapy rendered for treatment of Sickness at the Policyholder's Physical Therapy Health Clinic; or
- Outpatient Prescription Drugs when prescribed and filled at the Policyholder's Student Health Center]

Insured Percent	80% up to \$[2,000-5,000] then 100% up to the Enhanced Major Medical Aggregate Maximum Amount
------------------------	---

Enhanced medical Aggregate Maximum Amount Per Sickness or Injury	\$[250,000 to 1,000,000]
---	--------------------------

[The Basic and Enhanced Medical Benefit plans do not cover [Mental Disorders], [Outpatient Prescription Drugs prescribed for Sickness] or [Outpatient physical therapy for a Sickness] in excess of the Basic Medical Benefit plan maximum.]

Policy Year Maximum Benefit *

[Student]	[\$250,000, 300,000] [per Injury or Sickness]
[Dependent]	[\$100,000, 300,000] [per Injury or Sickness]

Per Condition Maximum Benefit *

[Student]	[\$25,000,50,000,100,000,200,000,250,000]
[Dependent]	[\$25,000,50,000,100,000,200,000,250,000]

[Except treatment of an Injury resulting from a motor vehicle accident] [5,000, 50,000-100,000]

[including Repatriation and Medical Evacuation]

Pre-Notification Penalty	[0, \$250, \$500, \$750]] [paid at the Out-of-Network Benefit Level]
Pre-Certifications Penalty	[0-100]% of the applicable Network Benefit Level]
[Pre-Certification Penalty	[paid at the Out-of-Network Benefit Level]
	payment is reduced by [\$500, 750, 1000] of the covered expense.] [paid at the Out-of-Network Benefit Level]

[If the Policy is excess, we will pay [an initial amount of [\$50, 100]] [for charges incurred [at the SHC][at the UCSF Medical Group]] for an Injury or Sickness and then we are secondary[, except Health Maintenance Organization (HMO) plans][, except for MediCal.]

[Out-of-Network claim payment - The methodology for calculating Reasonable and Customary is based upon the [50th,60th, 70th, 80th 90th] percentile of Ingenix and the prevailing rate in the community based upon zip code.

[* Combined [Student Health Center,] In-Network and Out-of-Network Benefit Levels]

Covered Services	[SHC]	In-Network Benefit Level	Out-of-Network Benefit Level
[Copayment][per office visit] [after first visit] [waived at the SHC]	\$[0-50]	\$[0-50]	\$[0-50]
[Copayments do not apply to Deductibles]			[Not applicable]]
[Copayments [including Prescription Copayments] do [not] apply to the Coinsurance Maximum Limit			
[Deductible,] [per Policy Year], [per Injury/] [Sickness] [Condition]	\$[0-1000]	\$[0-1000]	\$[0-1000]
[waived at the SHC]			
[waived in the case of an Emergency]			

[A new Deductible will apply each Policy Year. However, Covered Charges incurred during the last 3 months of a Policy Year which are applied to that Covered Person's Policy Year Deductible will also be applied toward that person's Deductible for the next Policy Year and thus reduce that Policy Year's Deductible.]

[Benefits are subject to Deductibles unless otherwise indicated.]

[The Deductible is waived for the Insured Student if the Insured Student first utilizes and/or is referred by the approved university Student Health Center or if the university Student Health Center is closed.]

expenses Incurred to meet the Deductible are cross applied [SHC], In-Network-Benefit and Out-of-Network Benefit.]

[The Deductible can be met by Student and [Family] [Dependent] expenses.]		[\$0] [N/A]	[\$50-2500]	[\$50-2500]
1.	[Single] [Student][Covered Person] Coverage			
2.	[Family] [Dependent] Coverage	[\$0] [N/A]	[\$50-2500]	[\$50-2500]
[Coinsurance Percentage] [except as specified herein]		[0-100%]	[0-100%][of Preferred Allowance]	[40-100%][of Reasonable and Customary expenses (R&C)]
[Coinsurance Maximum Limit, per Policy Year]		[\$500 to\$5000]	[\$500 to\$5000]	[\$500 to\$5000]
[Any Coinsurance paid by You is applied to the Coinsurance Maximum Limit per Policy Year]				
[Any Coinsurance paid by [Student and [Family] [Dependent] is applied to the Coinsurance Maximum Limit per Policy Year]				
[Once the Coinsurance Maximum Limit is reached by the Covered Person, the Coinsurance Percentage paid by the Company will be 100% In-Network and Out-of-Network.]				
1.	[Single] [Student][Covered Person] Coverage	[\$500 to\$5000]	[\$500 to \$6000]	[\$500 to 6000]
2.	[Family] [Dependent] Coverage	[\$500 to\$5000]	[\$500 to \$6000]	[\$500 to \$6000]

[PLEASE NOTE: ALL BENEFITS ARE PER POLICY YEAR UNLESS OTHERWISE NOTED.]

Covered Services	[SHC]	In-Network Benefit Level	Out-of- Network Benefit Level
Wellness Services (See Covered Services for more details)			
1. [Well Baby and child Care Age [0-18] and under]	[0-100% Coinsurance]	[0-100% Coinsurance]	[40-100% Coinsurance]
(Recommended immunization services covered at 100%)	[+ waiver of Deductible]	[+ waiver of Deductible]	[+ waiver of Deductible]
	[after Copayment]]	[after Copayment]	[after Copayment]
	[not covered at SHC]		[not covered Out-of-Network]
2. [Well Adult Care age [7, 17] and over Maximum payment not to exceed[\$100,\$250, 500] per Policy year]	[0-100% Coinsurance]	[0-100% Coinsurance]	[40-100% Coinsurance]
	[after Copayment]	[after Copayment]	[after Copayment]
	[+ waiver of Deductible]	[+ waiver of Deductible]	[+ waiver of Deductible]
	[Adult Dependent may use the SHC for adult wellness]	[Not covered outside the SHC]	[Not covered outside the SHC]
	[Annual physical is available for Student [and adult Dependent] at SHC only]		
a. [Coverage is limited to state mandate]	[0-100% Coinsurance]	[0-100% Coinsurance]	[40-100% Coinsurance]
	[after Copayment]	[after Copayment]	[after Copayment]
	[+ waiver of Deductible]	[+ waiver of Deductible]	[+ waiver of Deductible]
	[Adult Dependent may use the SHC for adult wellness]	[Not covered outside the SHC]	[Not covered outside the SHC]
	[Annual physical is available for Student [and adult Dependent] at SHC only]		

Covered Services	[SHC]	In-Network Benefit Level	Out-of- Network Benefit Level
b. [One (1) annual physical] or [PPD TB Test]	[0-100% Coinsurance] [after Copayment] [+ waiver of Deductible] [Adult Dependent may use the SHC for adult wellness] [Annual physical is available for Student [and adult Dependent] at SHC only]	[0-100% Coinsurance] [after Copayment] [+ waiver of Deductible] [Not covered outside the SHC]	[40-100% Coinsurance] [after Copayment] [+ waiver of Deductible] [Not covered outside the SHC]
3. [Adult Immunization[--Student Only]	[100% Coinsurance] [after Copayment] [after the Deductible] [+ waiver of Deductible] [[%] Coinsurance applied to all or select immunizations]	[% Coinsurance] [after Copayment] [+ waiver of Deductible] [not covered outside the SHC]	[%] Coinsurance] [after Copayment] [+ waiver of Deductible] [not covered outside the SHC]
Includes <ul style="list-style-type: none"> • [Tetanus], • [Measles-Mumps-Rubella], • [Travel inoculations] • [Hepatitis A] • [Hepatitis B][paid at 50%] • [HPV] • [Flu] • [Pneumonia] • [Varicella] • [Meningococcal] • [Twinrix (combo Hepatitis A and B)] 			
[up to a \$[100-500] Lifetime Aggregate Maximum]	[Adult Dependent may obtain immunizations at SHC]		

Covered Services	[SHC]	In-Network Benefit Level	Out-of- Network Benefit Level
Outpatient Services - (other than Maternity, Mental Health/Drug or Alcohol)			
1. [Doctor office visits]	[Copayment]	[Copayment]	[Copayment]
a. [Evaluation and Management]	[% Coinsurance]	[% Coinsurance]	[% Coinsurance]
	[after Copayment]	[after Copayment]	[after Copayment]
	[+ waiver of Deductible]	[+ waiver of Deductible]	[+ waiver of Deductible]
b. [Diagnostic services performed and billed by a Doctor's office]	[Copayment]	[Copayment]	[Copayment]
	[% Coinsurance]	[% Coinsurance]	[% Coinsurance]
	[after Copayment]	[after Copayment]	[after Copayment]
	[+ waiver of Deductible]	[+ waiver of Deductible]	[+ waiver of Deductible]
2. [Outpatient Health Care Facility fees including, related Doctor services]	[Copayment]	[Copayment]	[Copayment]
	[% Coinsurance]	[% Coinsurance]	[% Coinsurance]
	[after Copayment]	[after Copayment]	[after Copayment]
	[+ waiver of Deductible]	[+ waiver of Deductible]	[+ waiver of Deductible]
		[If an In-Network facility is utilized, Out-of-Network Provider claims will be processed at the In-Network benefit level once R&C is established.]	

Covered Services	[SHC]	In-Network Benefit Level	Out-of- Network Benefit Level
Outpatient Services (other than Maternity, Mental Health/Substance Abuse)			
3. [Diagnostic Imaging and Laboratory Procedures], [up to a \$[500-1,500] maximum per Condition]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible] [If an In-Network facility is utilized, Out-of-Network Provider claims will be processed at the In-Network benefit level once R&C is established.]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]
4. [CAT Scan, MRI, and /or PET Scans] ^[1] [Maximum We will pay combined is [\$500, 700, 1000, 2000] per Injury/Sickness/Condition per Covered Person]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible] [If an In-Network facility is utilized, Out-of-Network Provider claims will be processed at the In-Network benefit level once R&C is established.]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]
5. [Infusions and/or Injections done in an Outpatient Health Care Facility or Doctor's office] ^[1]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible] [If an In-Network facility is utilized, Out-of-Network Provider claims will be processed at the In-Network benefit level once R&C is established.]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]

Covered Services	[SHC]	In-Network Benefit Level	Out-of-Network Benefit Level
Outpatient Services:			
6. [Miscellaneous Outpatient Services]			
a. [including Radiation and Chemotherapy]	[Copayment]	[Copayment]	[Copayment]
	[% Coinsurance]	[% Coinsurance]	[% Coinsurance]
	[after Copayment]	[after Copayment]	[after Copayment]
	[+ waiver of Deductible]	[+ waiver of Deductible]	[+ waiver of Deductible]
		[If an In-Network facility is utilized, Out-of-Network Provider claims will be processed at the In-Network benefit level once R&C is established.]	
b. [Dialysis and Filtration Procedures]	[Copayment]	[Copayment]	[Copayment]
	[% Coinsurance]	[% Coinsurance]	[% Coinsurance]
	[after Copayment]	[after Copayment]	[after Copayment]
	[+ waiver of Deductible]	[+ waiver of Deductible]	[+ waiver of Deductible]
		[If an In-Network facility is utilized, Out-of-Network Provider claims will be processed at the In-Network benefit level once R&C is established.]	
Inpatient Services ^[1]			
1. [Hospital Services]	[Not Applicable]	[Copayment]	[Copayment]
		[% Coinsurance]	[% Coinsurance]
[Miscellaneous Hospital expenses limited to \$[500-2,000] for the first day of Hospitalization and \$[500-2,000] per day each day thereafter]		[after Copayment]	[after Copayment]
		[+ waiver of Deductible]	[+ waiver of Deductible]
		[If an In-Network facility is utilized, Out-of-Network Provider claims will be processed at the In-Network benefit level once R&C is established.]	

Covered Services	[SHC]	In-Network Benefit Level	Out-of-Network Benefit Level
a. [Room and Board expense, daily semi-private room rate and general nursing care provided by the Hospital.]	[Not Applicable]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]
b. [Intensive Care Room]	[Not Applicable]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]
c. [Consulting physician] [Up to \$[1,000-2500] maximum] [Doctor visits are limited to one visit per day [includes Consulting Physician]] [does not apply when related to surgery]	[Not Applicable]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]
d. [Pharmaceuticals administered while an Inpatient]	[Not Applicable]	[50-100]% of R&C	[50-100]% of R&C
e. [Skilled Nursing and Sub-Acute Care] [Maximum of [30-120] days], [per Injury] [per Sickness] [per Policy Year], [per Covered Person]]	[Not Applicable]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible] [If an In-Network facility is utilized, Out-of-Network Provider claims will be processed at the In-Network benefit level once R&C is established.]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]

Covered Services		[SHC]	In-Network Benefit Level	Out-of-Network Benefit Level
2.	[Inpatient rehabilitation]	[Not Applicable]	[Copayment]	[Copayment]
	[Maximum of [30-60] days], [per Injury] [per Sickness] [per Policy Year], [per Covered Person]]		[% Coinsurance]	[% Coinsurance]
			[after Copayment]	[after Copayment]
	[The maximum We will pay for Out-of-Network Inpatient rehabilitation charges is \$[500-2,000] per day, per Covered Person.]		[+ waiver of Deductible]	[+ waiver of Deductible]
			[If an In-Network facility is utilized, Out-of-Network Provider claims will be processed at the In-Network benefit level once R&C is established.]	[Not Applicable]
			[Not Applicable]	
Surgical Services ^[1]				
	[up to a \$[1,000-5,000] maximum]	[%] Coinsurance]	[%] Coinsurance]	[%] Coinsurance]
		[%] Coinsurance after Copayment]	[%] Coinsurance after Copayment]	[%] Coinsurance after Copayment]
			[If an In-Network facility is utilized, Out-of-Network Provider claims will be processed at the In-Network benefit level once R&C is established.]	
1.	[Surgeon]	[%] Coinsurance]	[%] Coinsurance]	[%] Coinsurance]
	[up to a \$[1,000-5,000] maximum]	[%] Coinsurance after Copayment]	[%] Coinsurance after Copayment]	[%] Coinsurance after Copayment]
			[If an In-Network facility is utilized, Out-of-Network Provider claims will be processed at the In-Network benefit level once R&C is established.]	

Covered Services	[SHC]	In-Network Benefit Level	Out-of- Network Benefit Level
2. [Assistant Surgeon]	[%] Coinsurance	[%] Coinsurance	[%] Coinsurance
	[%] Coinsurance after Copayment	[%] Coinsurance after Copayment	[%] Coinsurance after Copayment]
		[Up to [20- 25]% of Surgeon fees]	
		[If an In-Network facility is utilized, Out-of-Network Provider claims will be processed at the In-Network benefit level once R&C is established.]	[Up to [20- 25]% of Surgeon fees]
3. Anesthesia Services	[%] Coinsurance	[%] Coinsurance	[%] Coinsurance
[up to a \$[1,000-5,000 maximum]	[%] Coinsurance after Copayment	[%] Coinsurance after Copayment	[%] Coinsurance after Copayment]
[Out-of-Network Anesthesia charges will be paid at the In-Network Benefit level if an In- Network facility and Surgeon is used,]		[[80-100]% of R&C] [Up to [20-25]% of Surgeon fees]	[[80-100]% of R&C] [Up to [20- 25]% of Surgeon fees]
		[If an In-Network facility is utilized, Out-of-Network Provider claims will be processed at the In-Network benefit level once R&C is established.]	
4. [General Anesthesia for Dental services (See Covered Services for details)]	[%] Coinsurance	[%] Coinsurance	[%] Coinsurance
	[%] Coinsurance after Copayment	[%] Coinsurance after Copayment	[%] Coinsurance after Copayment]
		[If an In-Network facility is utilized, Out-of-Network Provider claims will be processed at the In-Network benefit level once R&C is established.]	

Covered Services	[SHC]	In-Network Benefit Level	Out-of- Network Benefit Level
5. [Outpatient Hospital/Health Care/Surgical Facility fee] [up to a \$[1,000-5,000] maximum]	[%] Coinsurance [%] Coinsurance after Copayment]	[%] Coinsurance [%] Coinsurance after Copayment] [If an In-Network facility is utilized, Out-of-Network Provider claims will be processed at the In-Network benefit level once R&C is established.]	[%] Coinsurance [%] Coinsurance after Copayment] [50-75%] Coinsurance
6. [Office Surgery performed in a Doctor's office]	[%] Coinsurance [%] Coinsurance after Copayment]	[%] Coinsurance [%] Coinsurance after Copayment]	[%] Coinsurance [%] Coinsurance after Copayment]
7. [Inpatient Hospital Facility Fee]	[%] Coinsurance [%] Coinsurance after Copayment]	[%] Coinsurance [%] Coinsurance after Copayment]	[%] Coinsurance [%] Coinsurance after Copayment]
8. [Oral Surgery for Accidental Injuries]	[%] Coinsurance [%] Coinsurance after Copayment]	[%] Coinsurance [%] Coinsurance after Copayment] [If an In-Network facility is utilized, Out-of-Network Provider claims will be processed at the In-Network benefit level once R&C is established.]	[%] Coinsurance [%] Coinsurance after Copayment]

Covered Services	[SHC]	In-Network Benefit Level	Out-of- Network Benefit Level
9. [Reconstructive Surgery] ^[1]	[%] Coinsurance	[%] Coinsurance	[%] Coinsurance]
	[%] Coinsurance after Copayment]	[%] Coinsurance after Copayment]	[%] Coinsurance after Copayment]
		[If an In-Network facility is utilized, Out-of-Network Provider claims will be processed at the In-Network benefit level once R&C is established.]	

[No more than one surgical procedure will be covered when multiple procedures are preformed through the same incision or in immediate succession]

[When Injury or Sickness requires multiple Surgical Procedures through the same incision, We will pay an amount not less than that for the most expensive procedure being performed. Multiple Surgical Procedures performed during the same operative session but through different incisions shall be reimbursed in an amount not less than the Covered Percentage of the Covered Charge of the most expensive Surgical Procedure then being performed, and with regard to the less expensive Surgical Procedure in an amount equal to 50% of the Covered Percentage of the Covered Charge for these procedures.] [\$[2,500-10,000]] allowed per surgical event]

Covered Services	[SHC]	In-Network Benefit Level	Out-of-Network Benefit Level
Reproductive Services			
1. [Maternity Care] ^[1]			
1. [Pre- and Post-Natal Care, including delivery and In-Hospital Doctor visits for mother and baby]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]
2. [Hospital services] ^[1]			
	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible] [If an In-Network facility is utilized, Out-of-Network Provider claims will be processed at the In-Network benefit level once R&C is established.]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]
c. [Diagnostic services performed and billed by a Doctor's office, including ultrasounds and amniocentesis] [(the 1 st ultrasound is 100%; subsequent ultrasounds are subject to Deductible & Coinsurance)]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]

Covered Services	[SHC]	In-Network Benefit Level	Out-of-Network Benefit Level
3. [Voluntary Sterilization Surgery]			
a. [Performed in a Doctor's office]	[Copayment]	[Copayment]	[Copayment]
	[% Coinsurance]	[% Coinsurance]	[% Coinsurance]
	[after Copayment]	[after Copayment]	[after Copayment]
	[+ waiver of Deductible]	[+ waiver of Deductible]	[+ waiver of Deductible]
b. [Performed in an Outpatient Hospital]	[Copayment]	[Copayment]	[Copayment]
	[% Coinsurance]	[% Coinsurance]	[% Coinsurance]
	[after Copayment]	[after Copayment]	[after Copayment]
	[+ waiver of Deductible]	[+ waiver of Deductible]	[+ waiver of Deductible]
		[If an In-Network facility is utilized, Out- of-Network Provider claims will be processed at the In- Network benefit level once R&C is established.]	
c. [Elective termination of pregnancy]	[Copayment]	[Copayment]	[Copayment]
[up to a \$[100-1,000] maximum]	[% Coinsurance]	[% Coinsurance]	[% Coinsurance]
	[after Copayment]	[after Copayment]	[after Copayment]
	[+ waiver of Deductible]	[+ waiver of Deductible]	[+ waiver of Deductible]

Covered Services	[SHC]	In-Network Benefit Level	Out-of-Network Benefit Level
Mental Disorder[([not]including Severe Mental Illness and Serious Emotional Disturbance of a Child)][and Alcoholism/Drug Abuse]			
a. Outpatient Office Visits ^[1] – [10,15, 20,30,40,50] visits ,[per Injury] [per Sickness] [per Policy Year], [per Covered Person]]	[Copayment] [% Coinsurance]	[Copayment] [50-100% Coinsurance]	[Copayment] [40-100% Coinsurance]
[up to a \$[500-2,500] maximum] [up to a \$[50-250] maximum per visit] [limited to one visit per [day][week]]	[after Copayment] [+ waiver of Deductible]	[after Copayment] [+ waiver of Deductible]	[after Copayment] [+ waiver of Deductible]
[for Dependents, up to a \$[500-2,500] maximum per Policy Year]			
b. Inpatient services ^[1] - [15, 20,25,30,40,50]days,[per Injury] [per Sickness] [per Policy Year], [per Covered Person]]	[Copayment] [% Coinsurance]	[Copayment] [% Coinsurance]	[Copayment] [% Coinsurance]
[up to a \$[500-2,500] maximum] [Doctor visits limited to \$[500-2,500], after Copayment]	[after Copayment] [+ waiver of Deductible]	[after Copayment] [+ waiver of Deductible]	[after Copayment] [+ waiver of Deductible]
		[up to 10 continuous days and 50% thereafter up to 35 additional days (100% if certified by Review Organization)]	[up to 10 continuous days and 50% thereafter up to 35 additional days (100% if certified by Review Organization)]

Covered Services	[SHC]	In-Network Benefit Level	Out-of-Network Benefit Level
[Alcoholism/Drug Abuse][Drug Abuse [(including Severe Mental Illness and Serious Emotional Disturbance of a Child)]			
a. Outpatient Office Visits ^[1] – [20,30,40,50] visits ,[per Injury] [per Sickness] [per Policy Year], [per Covered Person]]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]
b. Inpatient services ^[1] - [10, 20,30,40,50]days,[per Injury] [per Sickness] [per Policy Year], [per Covered Person]]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]	Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]	Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]
[Alcoholism]^[1]			
a. [Inpatient Alcoholism services – Limit of \$[500-2,500],[per Injury] [per Sickness] [per Policy Year], [per Covered Person]]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]
b. [Outpatient Alcoholism services – [20,30,40,50] visits ,[per Injury] [per Sickness] [per Policy Year], [per Covered Person]]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]

Covered Services	[SHC]	In-Network Benefit Level	Out-of-Network Benefit Level
[Urgent Care services] Copayment waived if referred to Emergency room or admitted to Hospital within [48,72] hours]	[Copayment]	[Copayment]	[Copayment]
	[% Coinsurance]	[% Coinsurance]	[% Coinsurance]
	[after Copayment]	[after Copayment]	[after Copayment]
[Note: The [Copayment] [Deductible]] amount, if any, for this visit is waived if You are referred to an Emergency room or admitted to a Hospital for the same Condition within [forty-eight (48), seventy-two (72)] hours of the visit.]	[+ waiver of Deductible]	[+ waiver of Deductible]	[+ waiver of Deductible]
[Follow up care at the Emergency room]	[Not covered]	[Not covered]	[Not covered]
[Emergency services] [[Copayment][ER Deductible] waived if admitted to Hospital [within [48,72] hours]] [or if Condition is life-threatening or would cause the Loss, or Loss of use, of a body part or organ] [or for treatment of a sexual assault] [includes after-hours charges] [Policy Year Deductible waived in the case of an Emergency] [for Injury, treatment must be within [forty-eight (48), seventy-two (72)] hours of Accident]	[Copayment]	[Copayment]	[Copayment]
	[% Coinsurance]	[% Coinsurance]	[% Coinsurance]
	[after Copayment]	[after Copayment]	[after Copayment]
	[+ waiver of Deductible]	[+ waiver of Deductible]	[+ waiver of Deductible]
	[+ waiver of Deductible]	[after \$[50-100] ER Deductible]	[after \$[50-100] ER Deductible]
		[[80-100]% when immediately followed by admittance or, after a \$[50-100] Deductible, [[50-80]% when not immediately followed by admittance]	[90% in the case of life-threatening Emergency]
		[Emergency care services are covered at [80-100%] for Emergency treatment received with in a [25-50]-mile radius of Student Health, when Student Health is closed, if immediately followed by admittance to Hospital for Inpatient treatment).]	[[50-80]% in the case of an Emergency, if outside a [25-50]-mile radius of the Student Health Center]
		[If an In-Network facility is utilized, Out-of-Network Provider claims will be processed at the In-Network benefit level once R&C is established.]	[Emergency care services are covered at [80-100%] for Emergency treatment received with in a [25-50]-mile radius of Student Health, when Student Health is closed, if immediately followed by admittance to Hospital for Inpatient treatment).]

Covered Services	[SHC]	In-Network Benefit Level	Out-of-Network Benefit Level
Emergency care Doctor		[50-100]% of R&C	[50-100]% of R&C
		[If an In-Network facility is utilized, Out-of-Network Provider claims will be processed at the In-Network benefit level once R&C is established.]	
[Follow up care at the Emergency room]	[Not covered]	[Not covered]	[Not covered]
Other Services			
1. [Allergy services]			
a. [Allergy Testing – [[1-3]series of tests,] [per Sickness] [per Policy Year], [per Covered Person]]	[Copayment]	[Copayment]	[Copayment]
	[% Coinsurance]	[% Coinsurance]	[% Coinsurance]
	[after Copayment]	[after Copayment]	[after Copayment]
	[+ waiver of Deductible]	[+ waiver of Deductible]	[+ waiver of Deductible]
		[Not covered outside SHC]	[Not covered outside SHC]
b. [Allergy Injections][Allergy treatment]	[Copayment]	[Copayment]	[Copayment]
[includes the following: treatment of anaphylaxis and angioedema, severe chronic sinusitis not responsive to medications and asthma not responding to usual treatments]	[% Coinsurance]	[% Coinsurance]	[% Coinsurance]
	[after Copayment]	[after Copayment]	[after Copayment]
	[+ waiver of Deductible]	[+ waiver of Deductible]	[+ waiver of Deductible]
	[+ waiver of Deductible]	[Not covered outside SHC]	[Not covered outside SHC]

Covered Services	[SHC]	In-Network Benefit Level	Out-of-Network Benefit Level
2. [Rehabilitative Care] -			
a. [Physical Therapy] ^[1]			
[Maximum Benefit \$[Copayment] per visit;]	[Copayment]	[Copayment]	[Copayment]
[\$500-2,000] [combined] [each] [PT] [OT]	[%	[% Coinsurance]	[% Coinsurance]
[ST]] [per Condition][per Policy Year]	Coinsurance]	[after Copayment]	[after Copayment]
	[after		
	Copayment]	[+ waiver of Deductible]	[+ waiver of
			Deductible]
	[+ waiver of		
	Deductible]		
[Maximum of [5, 10, 15, 20, 25, 30] visits [per			
Injury] [per Sickness] [per Policy Year], [per			
Covered Person]]			
[Copayment waived for first visit]			
[includes chiropractic care and acupuncture]			
[only for a Condition that required surgery or			
Hospital Confinement]			
[except for treatment received at the SHC]			
[limited to one visit per day]			
b. [Speech Therapy] ^[1]	[Copayment]	[Copayment]	[Copayment]
[Maximum Benefit [\$500-2,000]	[%	[% Coinsurance]	[% Coinsurance]
[combined] [each] [PT] [OT] [ST]]	Coinsurance]	[after Copayment]	[after Copayment]
[Maximum of [5-30] visits [per Injury] [per	[after		
Sickness] [per Policy Year], [per Covered	Copayment]	[+ waiver of Deductible]	[+ waiver of
Person]]			Deductible]
	[+ waiver of		
	Deductible]		
[limited to one (1) visit per day]			
c. [Occupational Therapy] ^[1]	[Copayment]	[Copayment]	[Copayment]
[Maximum Benefit [\$500-2,000]	[%Coinsurance]	[% Coinsurance]	[% Coinsurance]
[combined] [each] [PT] [OT] [ST]]	[after	[after Copayment]	[after Copayment]
[Maximum of [5-30] visits [per Injury] [per	Copayment]		
Sickness] [per Policy Year], [per Covered		[+ waiver of Deductible]	[+ waiver of
Person]]	[+ waiver of		Deductible]
	Deductible]		
d. [Cardiac/Pulmonary] ^[1]	[Copayment]	[Copayment]	[Copayment]
[Maximum We will pay is \$[500-2,000] per	[%	[% Coinsurance]	[% Coinsurance]
Injury] [per Sickness] [per Policy Year], [per	Coinsurance]	[after Copayment]	[after Copayment]
Covered Person]]	[after		
	Copayment]	[+ waiver of Deductible]	[+ waiver of
			Deductible]
	[+ waiver of		
	Deductible]		

Covered Services	[SHC]	In-Network Benefit Level	Out-of-Network Benefit Level
e. [Chiropractic] ^[1]	[Copayment]	[Copayment]	[Copayment]
[Maximum Benefit \$[Copayment] per visit;] \$[500-2,000] [combined] [each] [PT] [OT] [ST]] [per Condition][per Policy Year]	[% Coinsurance]	[% Coinsurance]	[% Coinsurance]
	[after Copayment]	[after Copayment]	[after Copayment]
[Maximum of [5-30] visits [per Injury] [per Sickness] [per Policy Year], [per Covered Person]]	[+ waiver of Deductible]	[+ waiver of Deductible]	[+ waiver of Deductible]
[limited to one (1) visit per day]			
f. [Acupuncture] ^[1]	[Copayment]	[Copayment]	[Copayment]
[Maximum Benefit \$[Copayment] per visit;] \$[500-2,000] [per Injury] [per Policy Year], [per Covered Person]]	[% Coinsurance]	[% Coinsurance]	[% Coinsurance]
	[after Copayment]	[after Copayment]	[after Copayment]
[Maximum of [5-30] visits [per Injury] [per Sickness] [per Policy Year], [per Covered Person]]	[+ waiver of Deductible]	[+ waiver of Deductible]	[+ waiver of Deductible]
[limited to one (1) visit per day]			
g. [Acupuncture and Chiropractic Combined] ^[1]	[Copayment]	[Copayment]	[Copayment]
[Maximum Benefit \$[Copayment] per visit;] \$[500-2,000] [per Injury] [per Policy Year], [per Covered Person]]	[% Coinsurance]	[% Coinsurance]	[% Coinsurance]
	[after Copayment]	[after Copayment]	[after Copayment]
[Maximum of [5-30] visits [per Injury] [per Sickness] [per Policy Year], [per Covered Person]]	[+ waiver of Deductible]	[+ waiver of Deductible]	[+ waiver of Deductible]
[limited to one (1) visit per day]			
h. [Podiatry]	[Copayment]	[Copayment]	[Copayment]
[Maximum Benefit \$[Copayment] per visit;] \$[500-2,000] [per Injury] [per Policy Year], [per Covered Person]]	[% Coinsurance]	[% Coinsurance]	[% Coinsurance]
	[after Copayment]	[after Copayment]	[after Copayment]
[limited to one (1) visit per day]	[+ waiver of Deductible]	[+ waiver of Deductible]	[+ waiver of Deductible]

	Covered Services	[SHC]	In-Network Benefit Level	Out-of-Network Benefit Level
2.	[Home Health Care services] ^[1] [The maximum We will pay is [10-100] visits per Injury] [per Sickness] [per Policy Year], [per Covered Person] [(four (4) hours or less = one (1) visit)]	[Not Applicable]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]
OR	[The maximum We will pay is \$[50-500]per Injury] [per Sickness] [per Policy Year], [per Covered Person] [(four (4) hours or less = one (1) visit)]			
3.	[Hospice] ^[1] [The maximum We will pay for bereavement services is [60, 90] days following the Covered Person's date of death] The maximum We will pay is [\$5000] per Injury] [per Policy Year], [per Covered Person]] [per lifetime]	[Not applicable]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]
4.	[Diabetic education] ^[1] [The maximum We will pay is \$[250-1,000] (per Injury) [per Sickness] [per Policy Year], [per Covered Person]]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]
5.	[Nutrition Counseling] ^[1] [The maximum We will pay is \$[250-1,000] [per Sickness] [per Policy Year], [per Covered Person]]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]
6.	[Prosthetic Appliances] ^[1] [The maximum We will pay for Prosthetics is \$[250-5,000][per Injury] [per Sickness] [per Policy Year], [per Covered Person]]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]

	Covered Services	[SHC]	In-Network Benefit Level	Out-of-Network Benefit Level
7.	[TMJ] [The maximum We will pay is \$[250-1,000] [per Injury] [per Sickness] [per Policy Year], [per Covered Person]]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]
8.	[PKU Testing & treatment]	[Not applicable]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]
9.	[Durable Medical Equipment] ^[1] [The maximum We will pay is \$[100-5,000] [per Injury] [per Sickness] [per Policy Year], [per Covered Person]] [Includes temporary surgical appliances]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]
10.	[Emergency Medical Transportation services] ^[1] [The maximum We will pay is \$[500-5,000] [per Injury] [per Sickness] [per Policy Year], [per Covered Person]] [Per Trip]	[Not applicable]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]
11.	[Eye Refractions, when performed in conjunction with a chronic or acute medical Condition. Note: Must be associated with an Illness code.]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]	[Copayment] [% Coinsurance] [after Copayment] [+ waiver of Deductible]

Covered Services	[SHC]	In-Network Benefit Level	Out-of-Network Benefit Level
12. [Repair of eye glasses, contact lens or hearing aids when required as a direct result of an Injury]	[Copayment]	[Copayment]	[Copayment]
	[% Coinsurance]	[% Coinsurance]	[% Coinsurance]
[The Maximum We will pay is \$[25-500] [per Injury] [per Sickness] [per Condition] [per Policy Year]]	[after Copayment]	[after Copayment]	[after Copayment]
	[+ waiver of Deductible]	[+ waiver of Deductible]	[+ waiver of Deductible]
13. Dental treatment due to Injury to Teeth [not including [broken fillings] [or] [damage caused by biting or chewing]	[Copayment]	[Copayment]	[Copayment]
	[% Coinsurance]	[% Coinsurance]	[% Coinsurance]
[The Maximum We will pay is \$[100-300] per tooth] [and] \$[250-1000] per Injury]	[after Copayment]	[after Copayment]	[after Copayment]
	[+ waiver of Deductible]	[+ waiver of Deductible]	[+ waiver of Deductible]
[treatment must be received within [5-90 days of Injury]		[If an In-Network facility is utilized, Out-of-Network Provider claims will be processed at the In-Network benefit level once R&C is established.]	

Covered Services	[SHC]	In-Network Benefit Level	Out-of-Network Benefit Level
14. [Blood and Body Fluid Needlestick Exposure]	[Copayment]	[Copayment]	[Copayment]
[The maximum We will pay is \$[1,000-25,000] [per exposure] [per Injury] [per Illness] [per Covered Person], [per Policy year.]]	[% Coinsurance]	[% Coinsurance]	[% Coinsurance]
	[after Copayment]	[after Copayment]	[after Copayment]
<ul style="list-style-type: none"> Coverage is for academic-related exposures only No referrals needed Covered in any geographic location in any medical facility 100% reimbursement for: <ul style="list-style-type: none"> a. Physician visits b. Lab tests done on the Student and the patient/donor involved in the exposure c. Emergency room visits, if necessary d. Medications necessary to treat exposure 	[+ waiver of Deductible]	[+ waiver of Deductible]	[+ waiver of Deductible]

[Enrollment:

1. Visiting medical Students must submit payment for this insurance Premium. The Needlestick Insurance enrollment form should be filled out and submitted with payment (by check or credit card authorization) with you visiting medical Student application. Checks should be made out to **[Nationwide Life Insurance Co]**.
2. Coverage will start the first day of the visiting medical Student's rotation, if the Premium is received by [TPA name]. The Needle-Stick Insurance enrollment form and payment should be submitted at least three weeks prior to the start date of the rotation for processing.
3. This information will be recorded in the Student Health Center (SHC) medical database and forwarded to [TPA name.], for processing.
4. An exposure (yellow) card for reference and Coverage confirmation will be given to the visiting medical Student at orientation on the first day.
5. Visiting medical Students may use the SHC for Coverage under this plan only.

Coverage under this plan will end on the last day of the visiting medical Student's rotation]

Covered Services	[SHC]	In-Network Benefit Level	Out-of-Network Benefit Level
[Retail Prescription Drugs - per prescription or refill [, subject to dispensing limits.]	[[30-80]% of charges] [[50-100]% after a Copayment of: \$[5-50] for each 30-day supply, \$[8-90] for each 60-day supply or \$[10-140] for each 90-day supply, if filled at SHC or if the SHC does not carry the drug, the SHC is closed, or when filled outside of a [25-50]-mile radius of the SHC] [brand name or Generic prescriptions for Accutane will be paid at [25-75]%]	[30-80% of charges] [[50-100]% after a Copayment of: \$[5-50] for each 30-day supply, \$[8-90] for each 60-day supply or \$[10-140] for each 90-day supply]	[30-80% of charges]
<ul style="list-style-type: none"> Generic Drugs (Tier 1) 	[% Coinsurance after [\$0, 10,15, 20] Copayment]	[50-100% Coinsurance + waiver of Deductible after] [\$10, 20, 25, 35, 45, 50] Copayment] [Accutane is subject to a [25-50]% Copayment]	[[% Coinsurance + waiver of Deductible after] [\$10, 20] Copayment] [Not covered]

Covered Services	[SHC]	In-Network Benefit Level	Out-of-Network Benefit Level
Note: Tier 2 has two option A or B			
<ul style="list-style-type: none"> [Formulary Brand Drugs (Tier 2)] 	[% Coinsurance after]	[% Coinsurance + waiver of Deductible after]	[% Coinsurance]
OR	[\$15, 20, 25, 30, 35, 50] Copayment]	[\$20, 25, 35, 45, 50] Copayment]	[Not covered]
<ul style="list-style-type: none"> [Formulary Brand Drugs, Non Formulary Brand Drugs, [Specialty Drugs (Non-Formulary, new Drugs and self injectables)] (Tier 2)] 		\$[10-25] in the event there is no Generic replacement for a prescribed Brand Name drug] [Accutane is subject to a [25-50]% Copayment]	
<ul style="list-style-type: none"> [Specialty Drugs (Non-Formulary Brand Drugs, new Drugs, and self injectables) (Tier 3)] 	[% Coinsurance + waiver of Deductible after]	[% Coinsurance + waiver of Deductible after]	[Not covered]
	You pay [30-80]% Coinsurance, with a minimum of \$[50-100] up to a maximum of \$[150- 500]]	You pay [30-80]% Coinsurance, with a minimum of \$[50-100] up to a maximum of \$[150- 500]]	
Annual maximum [\$1,000-5,000] [per Policy Year]			
[Only a 30 day supply can be dispensed at any time.]			
[One (1) Copayment per thirty (30) day supply]]			
[includes prescription contraceptives]			
[Prescriptions for [anti-fungal nail and nail pad medication/Therapy, including but not limited to] Lamisil and Sporanox are not covered.]			
[anti-malarials for prophylaxis are covered]			
[the Deductible [, excess provision,] and Pre-existing Condition Limitation are waived for prescriptions filled at the SHC [, for a drug the SHC does not carry or when filled outside of a [25-50]-mile radius of the SHC].]			
[Diabetic Supply Benefit – Annual maximum, separate from the pharmacy benefit maximum [\$500,1000,1500,2000]]	[% Coinsurance after [\$0, 10,15, 20] Copayment]	[50-100% Coinsurance + waiver of Deductible after]	[[% Coinsurance + waiver of Deductible after]
The following supplies are covered:			
<ul style="list-style-type: none"> Blood glucose testing device, including those designed to assist the visually impaired (one every three years) 		[\$10, 20, 25, 35, 45, 50] Copayment]	[\$10, 20] Copayment]
<ul style="list-style-type: none"> Blood glucose testing strips 			[Not covered]
<ul style="list-style-type: none"> Ketone urine testing strips 			
<ul style="list-style-type: none"> Lancets and lancet puncture devices 			
<ul style="list-style-type: none"> Pen delivery systems for the administration of insulin 			
<ul style="list-style-type: none"> Insulin syringes] 			

Covered Services	[SHC]	In-Network Benefit Level	Out-of-Network Benefit Level
[Mail Service Prescription Drugs - per prescription or refill, [subject to dispensing limits 30 days, 60 days, 90 days]. (In-Network Benefit only)]			
<ul style="list-style-type: none"> Generic Drugs (Tier 1) 	Not applicable	[% Coinsurance + waiver of Deductible after] \$[10-50] Copayment]	Not covered
Note: Tier 2 has two option A or B			
Or <ul style="list-style-type: none"> [Formulary Brand Drugs (Tier 2)] [Formulary Brand Drugs, Non Formulary Brand Drugs, [Specialty Drugs (Non-Formulary, new Drugs and self injectables)] (Tier 2)] 	Not applicable	[% Coinsurance + waiver of Deductible after] \$[25-100] Copayment]	Not covered
<ul style="list-style-type: none"> [Specialty Drugs (Non-Formulary Brand Drugs, new Drugs, and self injectables) (Tier 3)] 	Not applicable	[% Coinsurance + waiver of Deductible after] You pay [30-80%] Coinsurance, with a minimum of \$[50-100] up to a maximum of \$[150-500] for a 30 day supply]	Not covered
[Repatriation of Remains The maximum We will pay is \$[5000-10,000], per Covered Person]			
[Family companion benefit is limited to \$[1,000-5,000]]			
[Medical Evacuation [to home [state] [country]] The maximum We will pay is \$[5000-25,000], per Policy Year, per Covered Person]			
[Family companion benefit is limited to \$[1,000-5,000]]			

SCHEDULE OF BENEFITS

[ACCIDENTAL DEATH [AND DISMEMBERMENT BENEFITS] [AND LOSS OF SIGHT BENEFITS]

For Loss of:	Benefit Amount Student	Benefit Amount Dependent
Life	[0-\$25,000]	[0-\$25,000]
Both hands or both feet [or the entire sight of both eyes]	[0-\$25,000]	[0-\$25,000]
One hand and one foot	[0-\$25,000]	[0-\$25,000]
One hand	[0-\$25,000]	[0-\$25,000]
One foot	[0-\$25,000]	[0-\$25,000]
One hand or one foot [or the entire sight of one eye]	[0-\$25,000]	[0-\$25,000]
More than one of the above Losses due to one Accident	[0-\$25,000]	[0-\$25,000]
Thumb or Index Finger	[0-\$25,000]	[0-\$25,000]

Note: Loss shall mean, with regard to hands or arms and feet or legs, dismemberment by severance at or above the wrist or ankle joint, and with regard to eyes, entire or irrecoverable Loss of sight.

Only the largest benefit will be paid if more than one Loss results from any one Accident.]

GENERAL DEFINITIONS

The terms listed below, if used, have the meaning stated.

Accident: An event that is sudden, unexpected, and unintended, and over which the Covered Person has no control.

[Accidental Injury: A specific unforeseen event, which happens while the Covered Person is covered under this Policy and which directly, and from no other cause results in an Injury.]

[Acupuncturist: A Licensed Acupuncturist (L.Ac.) who is authorized by law and duly licensed by the appropriate State Regulatory Agency to perform acupuncture who does not ordinarily reside in the Covered Person's home or is not related to the Covered Person by blood or marriage.]

[Ambulatory Surgical Center: A facility which meets licensing and other legal requirements and which:

- Is equipped and operated to provide medical care and treatment by a Doctor;
- Does not provide services or accommodations for overnight stays;
- Has a medical staff that is supervised full time by a Doctor;
- Has full-time services of a licensed Registered Nurse (R.N.) at all times when patients are in the facility;
- Has at least one operating room and one recovery room and is equipped to support any surgery performed;
- Has x-ray and laboratory diagnostic facilities;
- Maintains a medical record for each patient; and
- Has a written agreement with at least one Hospital for the immediate transfer of patients who develop complications or need confinement.]

[Anesthetist: A Doctor duly licensed according to state law, who administers the anesthesia agent during a surgical procedure.]

[Assistant Surgeon: A Doctor who assists the Surgeon who actually performs a surgical procedure.]

[Attending Doctor: A Doctor who is charged with the overall care of the patient and who is responsible for directing the treatment program.]

[Basic Medical Benefits: The maximum lifetime benefit amount payable by the Company for incurred Covered Charges for each Injury or Sickness. When Injury or Sickness requires treatment, payment shall be made for Covered Charges incurred.]

[Benefit(s): The extent of those services listed in the Covered Charges.]

[Brand Name Prescription Drugs: Drugs for which the drug manufacturer's trademark registration is still valid, and who's trademarked or proprietary name of the drug still appears on the package label.]

[Coinsurance: The percentage of the expense for which the Company is responsible for a covered service. The Coinsurance is separate and not a part of the Deductible and Copayment.]

[Coinsurance Maximum Limit: The maximum amount of money a Covered Person pays for Coinsurance amounts in a Policy Year. This amount is shown on the Schedule of Benefits. There are separate Coinsurance Maximum Limit amounts for In-Network and Out-of-Network Benefit Levels.]

[Company: Nationwide Life Insurance Company. Also hereinafter referred to as We, Our and Us.]

[Complications of Pregnancy: A Condition which:

- When pregnancy is not terminated, requires medical treatment and the diagnosis is distinct from pregnancy but is adversely affected by or is caused by pregnancy, such as: (a) acute nephritis; (b) nephrosis; (c) cardiac decompensation; (d) missed abortion; (e) preeclampsia/eclampsia; (f) puerperal infection; (g) R.H. Factor problems; (h) severe Loss of blood requiring transfusion; (i) and other similar medical and surgical Conditions of comparable severity related to pregnancy; or
- When pregnancy is terminated: (a) non-elective cesarean section; (b) ectopic pregnancy that is terminated; and (c) spontaneous termination of pregnancy during a period of gestation in which a viable birth is not possible.

Complications of Pregnancy will **not** include:

- False labor;
- Occasional spotting;
- Doctor prescribed rest during the period of pregnancy;
- Morning Sickness; and
- Similar Conditions associated with the management of a difficult pregnancy but which are not a separate Complication of Pregnancy.]

[Condition: Disease, Illness, ailment, malfunction, [or pregnancy] of a Covered Person.]

[Confinement/Confined: An uninterrupted stay following admission to a Health Care Facility. The re-admission to a Health Care Facility for the same or related Condition, within a 72 hour period, will be considered a continuation of the Confinement. Confined/Confinement does **not** include observation, which is a review or assessment of [23, 18] hours or less, of a person's Condition that does not result in admission to a Hospital or Health Care Facility.]

[Copayment: A specified dollar amount a Covered Person must pay for specified charges. The Copayment is separate from and not a part of the Deductible or Coinsurance or out-of-pocket maximum.]

[Cosmetic Surgery or Plastic Surgery: Surgery intended primarily to alter normal structures of the body to improve appearance and that will result in only minimal functional improvement, except for Reconstructive Surgery as defined in this Policy.]

[Coverage: The right of the Covered Person to receive Benefits subject to the terms, Conditions, limitations and exclusions of the Policy.]

[Covered Charge or Covered Expense: As used herein means those charges for any treatment, services or supplies: (a) for Network Providers not in excess of the Preferred Allowance; (b) for Non-Network Providers not in excess of the charges of the Reasonable and Customary expense therefore; and (c) not in excess of the charges that would have been made in the absence of this insurance; and (d) incurred while this Policy is in force as to the Covered Person [except with respect to any covered expense payable under the Extension of Benefits Provision.]]

[Covered Person: A person:

- Who is eligible for Coverage as the Insured [or as a Dependent];
- Who has been accepted for Coverage [or has been automatically added];
- Who has paid the required Premium; and
- Whose Coverage has become effective and has not terminated.]

[Covered Services: Means the services and supplies, procedures and treatment described under Covered Services, subject to the terms, Conditions, limitations, and exclusions of the Policy.]

[Creditable Coverage:

- Any individual or group Policy, contract or program, that is written or administered by a disability insurance Company, health care service plan, fraternal Benefits society, self-Insured employer plan, or any other entity, and that arranges or provides medical, Hospital, and surgical Coverage not designed to supplement other private or governmental plans. The term includes continuation or conversion Coverage but does not include accident only, credit, Coverage for onsite medical clinics, disability income, Medicare supplement, long-term care insurance, dental, vision, Coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical payment insurance, or insurance under which Benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance Policy or equivalent self-insurance.
- The Federal Medicare programs pursuant to Title XVIII of the Social Security Act.
- The Medicaid program pursuant to Title XIX of the Social Security Act.
- Any other publicly sponsored program, provided in this state or elsewhere, of medical, Hospital and surgical care.
- 10 U.S.C.A. Chapter 55 (commencing with Section 1071) (Civilian Health and Medical Program of the Uniformed services (CHAMPUS)).
- A medical care program of the Indian Health Service or of a tribal organization.
- A state health Benefits risk pool.
- A health plan offered under 5 U.S.C.A. Chapter 89 (commencing with Section 8901) (Federal Employees Health Benefits Program (FEHBP)).
- A public health plan as defined in federal regulations authorized by Section 2701(c)(1)(I) of the Public Health Service Act, as amended by Public Law 104-191, the Health Insurance Portability and Accountability Act of 1996.
- A health Benefit plan under Section 5(e) of the Peace Corps Act (22 U.S.C.A. Sec. 2504(e)).
- Any other Creditable Coverage as defined by subsection (c) of Section 2701 of Title XXVII of the federal Public Health Services Act (42 U.S.C. Sec. 300gg(c)).]

[Custodial Care: Care that is primarily for the purpose of meeting non-medical personal needs, such as help with the activities of daily living and taking medications. Activities of daily living include, but are not limited to, bathing, dressing or grooming, eating, toileting, walking, and getting in and out of bed. Custodial Care can usually be provided by someone without professional medical skills or training.]

[Deductible: The amount of expenses for Covered services and supplies which must be incurred by the Covered Person before specified Benefits become payable.]

[Dependent: A person who is the Insured's:

- Legally married spouse, who is not legally separated from the Insured and resides with the Insured Student.
- Domestic Partner who resides with the Insured Student
- [Child who is Dependent upon the Insured for support and maintenance and is under the age of [19-30].
- [Child who is Dependent upon the Insured for support and maintenance, is [19-30] through [22 - 30] years of age and is attending school full time, as determined by the school the Dependent is attending, including colleges and vocational, technical, vocational-technical or trade schools or institutes.

The term child refers to the Insured's unmarried:

- Natural child;
- Stepchild or foster child; A stepchild is a Dependent on the date the Insured marries the child's parent.
- Adopted child, including a child placed with the Insured for the purpose of adoption, from the moment of placement as certified by the agency making the placement.
- Foster child is a Dependent from the moment of placement with the Insured as certified by the agency making the placement.]

[Doctor: Any of the following to the extent they are authorized by law and duly licensed by the appropriate State Regulatory Agency to perform a particular service which is covered under the Policy: Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) who does not ordinarily reside in the Covered Person's home or is not related to the Covered Person by blood or marriage.]

[Domestic Partner: Two individuals who, together, each meet all of the following criteria set forth below:

1. Are 18 years of age or older.
2. Are competent to enter into a contract.
3. Are not legally married to, nor the Domestic Partner of, any other person.
4. Are not related by marriage.
5. Are not related by blood closer than permitted under marriage laws of the state in which they reside.
6. Have entered into the Domestic Partner relationship voluntarily, willingly, and without reservation.
7. Have entered into a relationship which is the functional equivalent of a marriage, and which includes all of the following:
 - living together as a couple;
 - mutual support of each other;
 - mutual caring and commitment to each other;
 - mutual fidelity;
 - mutual responsibility for each other's welfare; and
 - joint responsibility for the necessities in life.
8. Have been living together as a couple for at least six (6) months prior to obtaining the Coverage provided under this Policy and the Certificate.
9. Intend to continue the Domestic Partner relationship indefinitely, while understanding that the relationship is terminable at the will of either partner.]

[Drug Abuse means any chemical component that one inhales, ingests, injects, or applies to one's body for purposes of non-therapeutic use. Drug Abuse does not include alcoholism or alcohol abuse.]

[Durable Medical Equipment: A device which:

- Is primarily and customarily used for medical purposes, is specially equipped with features and functions that are generally not required in the absence of Sickness or Injury and is able to withstand repeated use;
- Is used exclusively by the patient;
- Is routinely used in a Hospital but can be used effectively in a non-medical facility;
- Can be expected to make a meaningful contribution to treating the patient's Sickness or Injury; and
- Is prescribed by a Doctor and the device is Medically Necessary for rehabilitation.]

[Effective Date: The first date a Student or a covered Dependent becomes covered under this Policy.]

[Enhanced medical Aggregate Maximum Amount: The maximum amount of Benefits we will pay for any one Sickness or Injury under the Enhanced Major Medical expense Benefit while a Covered Person is covered under this Policy or any other Policy issued to the Policyholder by Us and is inclusive and cumulative of any and all periods of Coverage regardless of gaps in participation. The Major Medical Aggregate Maximum Amount is shown in the Schedule of Benefits.]

[Eligible Person: The Covered Person who is enrolled, [attending class] and meets the eligibility requirements of the Policyholder's school or [Dependents of the Covered Person].

[Emergency: A Sickness or Injury for which immediate medical treatment is sought at the nearest available facility. The Condition must be one which manifests itself by acute symptoms which are sufficiently severe (including severe pain) that a prudent layperson with average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in any of the following:

- Placing the health of the individual or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy;
- Serious impairment to bodily functions;
- Serious dysfunction of any bodily organ or part.]

Emergency Medical Transportation Services: A vehicle which is licensed solely as an ambulance by the local regulatory body to provide transportation to a Hospital or transportation from one Hospital to another for those individuals who are unable to travel to receive medical care by any other means or the Hospital cannot provide the

needed care. [Charges are payable only for transportation from the site of an Emergency to the nearest available Hospital that is equipped to treat the Condition].]

[Enhanced Major Medical Benefits: The amount payable by the Company after the maximum Benefit has been paid under the Comprehensive Major Medical Benefit. The maximum Benefit payable shall be inclusive of the Comprehensive Major Medical Benefits, for each Injury or Sickness. When a Covered Person selects the Enhanced Major Medical Benefits, the Covered Person automatically has Coverage provided under the Comprehensive Major Medical Benefits. When Injury or Sickness requires treatment and after the Maximum Benefit has been paid under the Comprehensive Major Medical Benefit plan, payment shall be made at percentage for covered Medical expenses incurred under the Enhanced Major Medical Benefits plan.]

[Evaluation and Management: Professional services provided by a Doctor or Health Care Practitioner in the Doctor's office or in an out patient or other ambulatory facility.]

[Expense Incurred: The charge made for a service, supply, or treatment that is a Covered Service under the Policy. The expense is considered to be incurred on the date the service or treatment is given or the supply is received.]

[Experimental/Investigational: The service or supply has not been demonstrated in scientifically valid clinical trials and research studies to be safe and effective for a particular indication. For further explanation, see definition of Medically Necessary/Medical Necessity]

[Family Member: A person who is related to the Covered Person in any of the following ways: spouse, brother-in-law, sister-in-law, son-in-law, daughter-in-law, mother-in-law, father-in-law, parent (includes stepparent), brother or sister (includes stepbrother or stepsister), or child (includes legally adopted, step or foster child). A Family Member includes an individual who normally lives in the Covered Person's household.]

[Formula: Enteral products for use at home that are prescribed by a Doctor, Health Care Practitioner upon referral by a health care Provider authorized to prescribe dietary treatments, as medically necessary for the treatment of phenylketonuria (PKU).]

[Generic Drugs: A non-brand name drug, which is a pharmaceutical equivalent to a Brand Name Prescription Drug, sold at a lower cost.]

[Habilitative Treatment or Therapy: treatment or Therapy that develops or attempts to develop a function that did not previously exist, but would normally be expected to exist. treatment or Therapy is considered Habilitative if the function has achieved maximal or optimal improvement or is static, showing no progressive improvement with additional treatment.]

[Health Care Facility: A Student Health Center, Hospital, [Skilled Nursing, Sub-Acute,] Hospice, or other duly licensed, certified and approved health care institution which provides care and treatment for sick or injured persons.]

[Health Care Practitioner: Includes but is not limited to: A Doctor of Dentistry (D.D.S. or D.M.D.), Doctor of Podiatry (D.P.M.), Doctor of Optometry (O.D.), Doctor of Chiropractic (D.C.), Doctor's Assistant (P.A.), Psychologists (Ph. D.), Nurse (R.N. or L.P.N), which may include Nurse Midwife, Nurse Anesthetist, and Nurse Practitioner, a Licensed Clinical Social Worker (L.C.S.W.), Physical Therapist (P.T. or R.P.T.), Occupational Therapist (O.T.R.), Speech Pathologist, Audiologist, Marriage and Family Therapist (M.F.T. or M.S.W.), Respiratory Care Practitioner, or Registered Dietitian (R.D.) all of whom are (a) properly licensed or certified to provide medical care under the laws of the state of practice; (b) provide medical services within the scope of the license or certificate; and (c) does not ordinarily reside in the Covered Person's home or is not related to the Covered Person by blood or marriage.]

[Home Health Care: Services and supplies that is Medically Necessary for the care and treatment of a covered Illness or Accidental Injury that are furnished to a Covered Person at the Covered Person's residence.

Home Health Care consists of, but shall not be limited to, the following:

- Part-time or intermittent skilled nursing services provided by a Registered Nurse or licensed Vocational Nurse;
- Part-time or intermittent home health aide services which provide supportive services in the home under the supervision of a Registered Nurse or a Physical Therapist; and
- Physical therapy.]

[Home Infusion Therapy: The continuous Infusion of prescribed blended Drugs, as prescribed by the Attending Doctor, representing direct treatment of a specific covered Illness or Accidental Injury. The treatment is provided in the Covered Person's home.]

[Hospice: A coordinated plan of home and Inpatient care which treats the terminally ill patient and family as a unit. It provides care to meet the special needs of a family unit during the final stages of a terminal Illness and during the bereavement. Care is provided by a team of trained medical personnel, homemakers, and counselors. The team acts under an independent Hospice administration. It helps the family unit cope with physical, psychological, spiritual, social, and economic stresses.]

[Hospital: A facility which provides diagnosis, treatment, and care of persons who need acute Inpatient Hospital care under the supervision of Doctors. It must be licensed as a general acute care Hospital according to state and local laws. Hospital shall also include a psychiatric health facility for the treatment of mental or psychoneurotic disorders.

Facilities primarily treating drug addiction or alcoholism that are licensed to provide these services are also included in this definition. Hospital does not include an institution, or part thereof, which is other than incidentally a nursing home, a convalescent Hospital, or a place for rest or the aged.]

[Hospital Confined/Hospital Confinement: Confinement in a Hospital for at least [nineteen (19), twenty-four (24)] hours or greater for which a room and board charge is made by reason of Sickness or Injury for which Benefits are payable. The readmission for the same or related Sickness or Injury, within a seventy-two (72) hour period, will be considered a continuation of confinement.]

[Identification Card: Your Identification Card identifies You as a Covered Person.]

[Illness: Sickness or disease.]

[Infusion/Injectable Services: Services provided in an office or Outpatient facility, or by a licensed Infusion or health care agency, including the professional fee and related supplies. Infusion/Injectable Services does [not] include self-administered Injectable Drugs.]

[Injury: Bodily Injury due to a sudden, unforeseeable, external event which:

- Results solely, directly and independently of disease, bodily infirmity or any other causes;
- [Occurs after the Covered Person's Effective Date of Coverage;]
- Occurs while Coverage is in force.

All injuries sustained in any one Accident, including all related Conditions and recurrent symptoms of these injuries, are considered a single Injury.]

[In-Network Benefit Level: The highest level of payment made by Us for Covered Services under the terms of the Policy.]

[Inpatient/Inpatient Admission: A confinement of [nineteen (19), twenty-four (24)] hours or greater.]

[Insured: The Covered Person who is enrolled at and meets the eligibility requirements of the Policyholder's school [or Dependents of the Covered Person.]

[Lifetime Aggregate Maximum: The amount payable by the Company for incurred Covered Charges for all Injuries or Sicknesses and will never exceed an amount determined by subtracting from the sum of \$[10,000 to \$1,000,000] from the following: (i) all amounts paid under this Policy for all Injuries or Sicknesses; (ii) all amounts

paid to or in respect of an Insured for all Injuries or Sicknesses under any other Policy issued to the Policyholder by this Company, regardless of the Policy period of such other Policy.

The Maximum Benefit for all benefit Coverage afforded under this Policy is \$[10,000 to \$1,000,000] for all Injuries or Sicknesses. Covered Charges shall not include amounts paid by the Insured for Coinsurance.]

[Lifestyle Change: A change in Your or Your Dependent's status due to marriage, divorce, [dissolution of Domestic Partnership], age, birth, death, adoption, change in Spouse's [or Domestic Partner's] employment or health insurance or health plan Coverage, eligibility for Medicare, change in Student status or any other event which impacts eligibility for Coverage under the Policy.]

[Life-Threatening Condition: Diseases or Conditions where the likelihood of death is high unless the course of the disease is interrupted; or with potentially fatal outcomes, where the end point of clinical intervention is survival.]

[Loss: Medical expenses covered by this Policy as a result of Injury or Sickness as defined in this Policy.]

[Major Medical Aggregate Maximum Amount: The maximum amount of Benefits we will pay for any one Sickness or Injury under the Major Medical expense Benefit while a Covered Person is covered under this Policy or any other Policy issued to the Policyholder by Us and is inclusive and cumulative of any and all periods of Coverage regardless of gaps in participation. The Major Medical Aggregate Maximum Amount is shown in the Schedule of Benefits.]

[Maximum Benefit: The maximum payment We will make under the Policy for each Covered Person for Covered Services. This amount is shown on the Schedule of Benefits.]

[Medical Emergency: The unexpected onset of an Injury or Sickness which requires immediate or urgent medical attention which, if not provided, could result in a Loss of life or serious permanent damage to a limb or organ or pain sufficient to warrant immediate care. A Medical Emergency does not include elective surgery, elective treatment or routine care.]

[Medically Necessary/Medical Necessity: A treatment, drug, device, procedure, supply or service that is necessary and appropriate for the diagnosis or treatment of Sickness or Injury in accordance with generally accepted standards of medical practice in the United States at the time it is provided. [When specifically applied to Hospital Confinement, it means that the diagnosis or treatment of symptoms or a Condition cannot be safely provided on an Outpatient basis.

A treatment, drug, device, procedure, supply or service shall not be considered as Medically Necessary if it:

- Is Experimental/Investigational or for research purposes;
- Is provided solely for educational purposes or the convenience of the patient, the patient's family, Doctor, Hospital or any other Provider;
- Exceeds in scope, duration or intensity that level of care that is needed to provide safe, adequate and appropriate diagnosis or treatment and where ongoing treatment is merely for maintenance or Preventive Care;
- Could have been omitted without adversely affecting the patient's Condition or the quality of medical care;
- Involves treatment with or the use of a medical device, drug or substance not formally approved by the U.S. Food and Drug Administration (FDA). If the prescribed drug is recognized as safe and effective for the treatment of a Sickness or Injury by one or more of the Standard Medical Reference Compendia or in the Medical Literature, even if the prescribed drug has not been approved by the FDA for the treatment of that specific Sickness or Injury, Coverage will be provided, subject to the exclusions and limitations of the Policy;
- Involves a service, supply or drug not considered reasonable and necessary by the Healthcare Financing Administration Medicare Coverage Issues Manual; or
- Can be safely provided to the patient on a more cost-effective basis such as Outpatient, by a different medical professional, or pursuant to a more conservative form of treatment.

We reserve the right to determine whether a service, supply or drug is Medically Necessary.]

[Mental Disorder: Nervous, emotional, and mental disease, illness, syndrome or dysfunction classified in the most recent addition of the Diagnostic and Statistical Manual of Mental Disorders (DSM IV) or its successor, as a Mental Disorder on the date of medical care or treatment is rendered to a Covered Person.]

[Network Providers: Doctors, Hospitals and other healthcare Providers who have contracted to provide specific medical care at negotiated prices.]

[Non-Network Providers: Have not agreed to any pre-arranged fee schedules.]

[Nurse: A licensed Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.) who: (a) is properly licensed or certified to provide medical care under the laws of the state where the nurse practices; and (b) provides medical services which are within the scope of the nurse's license or certificate who does not ordinarily reside in the Covered Person's home or is not related to the Covered Person by blood or marriage.]

[Office Surgery (ies): An invasive procedure to repair, replace, remove or add tissue or fluid. The procedural coding represents that found under the surgical codes as outlined in the Current Procedural Terminology Manual (CPT).]

[Orthognathic Surgery: A surgical procedure which reconstructs the bones of the jaw. Facial reconstructive surgery is covered when the Covered Person has a defect or deformity of the facial and/or jawbones (documented by CT/MRI/or x-ray) that may be life threatening or documented to be proposed for a medical physiological functional impairment presently being addressed. Usual causes of such acquired Conditions include local trauma, infection, neoplasm, inflammatory processes or vascular insufficiency which result in destruction or deformity of the affected bone. This does not include oral appliances/orthotics.]

[Other Medical Care Practitioner: Upon referral by a Doctor, a licensed Clinical Social Worker (L.C.S.W.), Physical Therapist (P.T. or R.P.T.), Occupational Therapist (O.T.R.), Speech Pathologist, Audiologist, Marriage and Family Therapist (M.F.T. or M.S.W.), Respiratory Care Practitioner, or Registered Dietitian (R.D.), who does not ordinarily reside in the Covered Person's home or is not related to the Covered Person by blood or marriage.]

[Out-of-Network Benefit Level: The lowest level of payment made by Us for Covered Services under the terms of the Policy.]

[Outpatient: Not confined in a Hospital, Skilled Nursing facility or Hospice as a registered bed patient.]

[Partial Hospital Mental Health Confinement: A structured program of active treatment for psychiatric care for Mental Disorders, alcoholism and/or Drug Abuse and/or addiction received on an Outpatient basis at a Hospital. Such program may include, but is not limited to, Doctor or Other Medical Care Practitioner visits, dietary counseling, physical activities, and room and meal services. This includes day treatment or residential treatment centers.]

[Per Condition Aggregate Maximum: The amount payable by the Company for incurred Covered Charges for each Injury or Sickness and will never exceed an amount determined by subtracting from the sum of \$[10,000 to \$1,000,000] following: (i) all amounts paid under this Policy for each Injury or Sickness; (ii) all amounts paid to or in respect of an Insured for each Injury or Sickness under any other Policy issued to the Policyholder by this Company, regardless of the Policy period of such other Policy.]

[Policy: The agreement between Us and the Policyholder which states the terms, Conditions, limitations and exclusions regarding Coverage.]

[Policy Year: The period of twelve (12) months following the Policy's Effective Date.]

[Policy Year Maximum Limit: The maximum payment We will make under the Policy for each Covered Person for Covered Services.]

[Policyholder: The entity shown as the Policyholder on the Policy face page.]

[Pre-admission Testing: Tests done in conjunction with a scheduled surgery where a operating room has been reserved before the tests are done.]

[Pre-existing Condition: A Sickness or Injury for which [symptoms,] medical care, treatment, diagnosis or advice was received or recommended within the [three (3), six (6), twelve (12)] consecutive months prior to the Covered Person's Effective Date of Coverage under the Policy. Pre existing Condition means any Condition [(a) that would have caused an ordinary prudent person to seek medical advice, diagnosis, care or treatment during the [three (3), six (6), twelve (12)] months immediately prior to an Insured's Effective Date of Coverage;] [(b) for which medical advice, diagnosis, care or treatment was recommended or received within the [three (3), six (6), twelve (12)] months immediately prior to an Insured's Effective Date of Coverage; or] [(c) a pregnancy existing on the Insured's Effective Date of Coverage.]

[Preferred Allowance: The amount a Network Provider has agreed to accept as payment in full for Covered Charges.]

[Preferred Provider Organization or PPO: The entity named in the Schedule of Benefits.]

[Premium: The amount required to maintain Coverage for each Eligible Person and Dependent in accordance with the terms of this Policy.]

[Prescription Drugs: Drugs which may only be dispensed by written prescription under Federal law, and approved for general use by the U.S. Food and Drug Administration (FDA). The Drugs must be dispensed by a licensed pharmacy Provider for out of Hospital use. Coverage for a Prescription Drug will not be excluded for a particular indication on the grounds that the drug has not been approved by the FDA for that indication, if such drug is recognized for treatment of such indication in one of the standard reference compendia or in the medical literature as recommended by current American Medical Association (AMA) policies. Prescription Drug Coverage shall also include Medically Necessary supplies associated with the administration of the drug.]

[Preventive Care: Comprehensive Preventive Care of Dependent children:

- That is consistent with the most current version of the Recommended Childhood Immunization Schedule/United States, jointly adopted by the American Academy of Pediatrics, the Advisory Committee on Immunization Practices, and the American Academy of Family Doctors; and
- Provides for periodic health evaluations, immunizations and laboratory services in connection with periodic health evaluations.]

[Provider: A Doctor, Health Care Facility, Urgent Care Facility, or Health Care Practitioner that is licensed or certified to provide medical services or supplies.]

[Rehabilitative: The process of restoring a person's ability to live and work after a disabling Condition by:

- Helping the person achieve the maximum possible physical and psychological fitness;
- Helping the person regain the ability to care for himself or herself;
- Offering assistance with relearning skills needed in everyday activities, with occupational training and guidance and with psychological readjustment.]

[Reasonable and Customary expense: The most common charge for similar professional services, drugs, procedures, devices, supplies or treatment within the area in which the charge is incurred, so long as those charges are reasonable. The most common charge means the lesser of:

- The actual amount charged by the Provider;
- [The negotiated rate, if any; or]
- The charge which would have been made by the Provider of medical services for a comparable service or supply made by other Providers in the same geographic area, as reasonably determined by Us for the same service or supply.

Geographic area means the first three digits of the zip code in which the service, treatment, procedure, drugs or supplies are provided or a greater area, if necessary, to obtain a representative cross-section of charge for a like treatment, service, procedure, device, drug or supply.

Reasonable charges, fees or expenses as used herein to describe expense, will be considered to mean the percentile of the payment system in effect on the Effective Date as shown on the face page of this Policy.

No payment will be made under this Policy for any expenses incurred which in the judgment of the Company are in excess of Reasonable and Customary expense.]

[Reconstructive Surgery: Surgery performed to correct or repair abnormal structures of the body caused by [congenital defects,] developmental abnormalities, trauma, infection, tumors, disease, or Accidental Injury occurring while Insured under this Policy to either: (1) improve function or (2) create a normal appearance.]

[Reservist: A member of a reserve component of the Armed Forces of the United States. Reservist also includes a member of the State National Guard and the State Air National Guard.]

[Review Organization: Entity named in the Schedule of Benefits.]

[Screening Mammography: A radiological examination utilized to detect unsuspected breast cancer at an early stage in asymptomatic women and includes the x-ray or digital radiography examination of the breast using equipment that is dedicated specifically for mammography, including, but not limited to the x-ray tube, filter, compression device, screens, film, and cassettes, and that has an average radiation exposure delivery of less than one rad mid-breast. Screening Mammography includes two views for each breast and includes the professional interpretation of the films. Screening Mammography does not include diagnostic mammography. Screening Mammography must be performed in a facility or mobile mammography screening unit that is accredited under the American College of Radiology Mammography Accreditation Program or in a Hospital.]

[Serious Emotional Disturbance of a Child: A child under the age of [0-18] who has one or more mental disorders as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, other than a primary substance use disorder or developmental disorder that result in behavior inappropriate to the child's age according to expected developmental norms.]

[Severe Mental Illness: Schizophrenia; schizoaffective disorder; bipolar disorder (manic-depressive Illness); major depressive disorders; panic disorder; obsessive-compulsive disorder; pervasive developmental disorder or autism; anorexia nervosa; and bulimia nervosa.]

[Sickness: Illness, disease, pregnancy and Complications of Pregnancy. All related Conditions and recurrent symptoms of the same or a similar Condition will be considered the same Sickness.]

[Skilled Nursing Care: Services that are certified as Medically Necessary by a Doctor and are not intermediate, domiciliary, custodial or retirement care.]

[Skilled Nursing Facility: A place (including a separate part of a Hospital) which:

- Regularly provides room and board for person(s) recovering from Illness or Accidental Injury;
- Provides continuous twenty-four (24) hour nursing care by or under the supervision of a Registered Nurse;
- Is under the supervision of a duly licensed Doctor;
- Maintains a daily clinical record for each patient;
- Is not, other than incidentally, a place for rest, the aged, place of treatment for alcoholism or drug and/or substance abuse or addiction; and
- Is operated pursuant to law.]

[Special Food Product: A food product that is both of the following: (a) prescribed for the treatment of phenylketonuria (PKU) and is consistent with the recommendations of best practices of qualified health professionals with expertise to, and experience in the treatment and care of PKU. It does not include food that is naturally low in protein, but may include a food product that is specially formulated to have less than one gram of protein per serving; and (b) used in place of normal food products, such as grocery store foods, used in the general population.]

[Specialty Drugs: Means a drug or category of drugs that meet any of the following criteria: the drug (i) is produced through biotechnology or recombinant DNA technology mechanism, (ii) is considered to be high cost, (iii)

is self administered by injection and/or Infusion or (iv) requires special patient monitoring, or (v) requires special handling or (vi) has restricted distribution procedures.]

[Student: A registered Student, [resident] [fellow]. [postdoctoral fellow], [domestic], [international Student] who is enrolled in a participating college, [taking at least [1-15] credit hours or more] and [is physically and actively attending classes for at least [1-31] days after their Effective Date of Coverage under the Policy]..

[Sub-Acute Facility: A free-standing facility or part of a Hospital that is certified by Medicare to accept patients in need of Rehabilitative and Skilled Care Nursing.]

[Surgeon: A Doctor who actually performs surgical procedures.]

[Surgical Services: Surgical Services include both facility and Provider fees associated with any surgery, whether done as an Inpatient, Outpatient or in a Doctor's office. Benefits are paid at the Surgical Services Benefit shown on the Schedule of Benefits services include:

- Surgeon and Assistant Surgeon
- Anesthesia
- Facility fees
- Supplies, drugs, and miscellaneous items used in association with the surgical event.]

[Surrogate Parenting Agreement: One in which a woman agrees to become pregnant with the intent of surrendering custody of the child.]

[Teeth: The major portion of the individual tooth which is present, regardless of filings and caps; and is not carious, abscessed, or defective.]

[Urgent Care: Means short-term medical care for non-life threatening Conditions that can be mitigated or require care within [forty-eight (48) or seventy-two (72)] hours of onset.]

[Urgent Care Facility: a Hospital or other licensed facility which provides diagnosis, treatment, and care of persons who need acute care under the supervision of Doctors.]

[Vision Screening: A screening to determine if there are underlying medical Conditions or if a refractive exam needs to be performed. Vision Screening does not include refractive exams, which are not covered as specified in the General Exclusions and Limitations.]

[We, Our and Us: Nationwide Life Insurance Company.]

[You and Your: the Covered Person.]

Male pronouns whenever used include female pronouns

ELIGIBILITY

We maintain the right to investigate Student status and attendance records to verify that the Policy eligibility requirements have been met. If We discover that the Policy eligibility requirements have not been met, Our only obligation is refund of Premium.

All registered Students who pay [full registration fees] and [actively attend class] or [have matriculated] at the Policyholder's school for at least the first [thirty-one (0-31)] days of the Policy Term are [eligible to enroll] [are automatically enrolled] in the Policy [for the Fall, Winter, Spring] [for the Fall, Winter, Spring, and Summer Terms] [for the term enrolled]. Except in the case of medical withdrawal due to Sickness or Injury, any Student withdrawing from school during the first [thirty-one (0-31)] days of the period for which Coverage is purchased, will not be covered under this Policy and a full refund of Premium will be made minus the cost of any claim Benefits made by Us. Students withdrawing after such [thirty-one (0-31)] days will remain covered under the Policy for the term purchased and no refund will be allowed.

Each Student, as determined by the school and the Company, is eligible for Coverage under this Policy.

[CREDIT HOUR REQUIREMENTS]

Students registered for more than [one (1) –fifteen (15)] credits in a quarter/semester.

[Scholars, visiting and otherwise defined by the school]

[The following courses are excluded from being applied towards the required minimum credit hours:

- Distance Learning Courses
- Courses taken as audit
- Courses taken as Pass/Non-Pass
- Courses taken Grad Non-Degree
- Home Study
- Correspondence
- TV courses]

[DEPENDENTS ACQUIRED AFTER EFFECTIVE DATE]

Newborn Children: An Insured's newborn child is automatically covered from the moment of birth until such child is **ninety (90)** days old. Coverage for such child will be for Sickness and Injury, including medically diagnosed congenital defects, birth abnormalities, prematurity and nursery care. However, the Insured must notify Us in writing within thirty-one (31) days of such birth and pay the required additional Premium, if any, in order to have Coverage for the newborn child continue beyond such **ninety (90)** day period.

Step-Child: Coverage for a Step-Child is effective on the date the Insured marries the child's parent. However, the Insured must notify Us in writing within thirty-one (31) days of the marriage and pay the required additional Premium, if any, in order to have Coverage for the child continue beyond such thirty-one (31) day period.

Foster Child: Coverage for a Foster Child is effective upon the date of placement with the Covered Person. Coverage for such child will be for Sickness and Injury, including medically diagnosed congenital defects, birth abnormalities, prematurity and nursery care. Coverage will continue unless the placement is disrupted and the child is removed from placement. However, the Insured must notify Us in writing within thirty-one (31) days of such placement and pay the required additional Premium, if any, in order to have Coverage for the Foster Child continue beyond such thirty-one (31) day period.

Adopted Child: Coverage for an adopted child is effective upon the earlier of the date of placement for the purpose of adoption, **the date the petition to adopt is filed as long as the Insured notifies us within 60 days**, or the date of the entry of an order granting the adoptive parent custody of the child for purposes of adoption. Coverage for such child will be for Sickness and Injury, including medically diagnosed congenital defects, birth abnormalities, prematurity and nursery care. Coverage will continue unless the placement is disrupted prior to legal adoption and the child is removed from placement. However, the Insured must notify Us in writing within thirty-one (31) days of such adoption and pay the required additional Premium, if any, in order to have Coverage for the adopted child continue beyond such thirty-one (31) day period.

Dependent Spouse/Domestic Partner: A Dependent spouse or Domestic Partner is eligible for Coverage on the date of marriage to the Insured or the date the Domestic Partnership begins. Enrollment and Premium must be received within thirty-one (31) days of the marriage or the date the Domestic Partnership begins. Coverage is effective upon enrollment and receipt of Premium by Us or Our authorized representative.]

[TERMINATION]

Policyholder: The Policy is issued for the Policy term stated on the face page of this Policy on the Effective Date of the Policy. If the Policyholder desires to continue Coverage, We will issue a new Policy for a new Policy term, subject to the then current underwriting requirements.

Covered Person: Coverage will terminate at 12:01 a.m. standard time at the Covered Person's residence on the earliest of:

- The termination date of the Policy;
- The date the Insured ceases to be an Eligible Person;
- [The day after the last day of study in the sponsored program;]
- [The date of departure to the United States;]
- The last day of the [term of Coverage] [Policy term] for which Premium is paid;
- The date the Covered Person departs the Policyholder's school for their home country for a period in excess of [thirty (30), sixty (60), ninety (90)] consecutive days. No Benefits will be payable for any medical treatment received in the Covered Person's Home Country.
- The last date of the period for which Premium has been paid following the date a Dependent ceases to be a Dependent as defined;
- The date a Covered Person enters full time active military service. [Upon written request [within [fifteen (15) – sixty (60)] days of leaving school], We will refund any unearned pro-rata Premium with respect to such person.] [We will refund the unearned pro-rata Premium to such person upon request.]
- Handicapped Dependent child who is not capable of supporting himself or herself due to mental retardation or physical handicap will be continued beyond the age at which Coverage would otherwise have terminated if:
 1. The Dependent child became incapacitated prior to the age at which Coverage would otherwise have terminated; and
 2. The Dependent child is primarily Dependent on the Eligible Person for support and maintenance; and
 3. Proof of such incapacity and dependence is given to Us by a Doctor Proof must also be given to Us annually thereafter.

Coverage will continue as long as the Dependent continues to be so incapacitated and Dependent, unless otherwise terminated in accordance with the terms of the Policy.

[Termination is subject to the Extension of Benefits provision.]

[EXTENSION OF BENEFITS]

The Coverage provided under this Policy ceases on the termination date, shown on the face page. However, if an Insured is [Hospital Confined on the termination date from a covered Injury or Sickness for which Benefits were paid before the termination date] or [Totally Disabled on the termination date from a covered Injury or Sickness for which Benefits were paid before the termination date], Covered expenses for such Injury or Sickness will continue to be paid for a period of [thirty (30), sixty (60) ,ninety (90)] days or [until date of discharge], whichever is earlier.

[With respect to the Insured, the inability to attend classes at the location where enrolled].

The total payments made in respect of the Insured for such Condition both before and after the termination date will never exceed the Maximum Benefit. After this Extension of Benefits provision has been exhausted, all Benefits cease to exist and under no circumstances will further Benefits be made.

[Dependents that are newly acquired during the Insured Student's Extension of Benefits period are not eligible for Benefits under the provision.]

[CONTINUATION OF COVERAGE]

The right to continue this Coverage is available to an Insured who is no longer an Eligible Person. Application for continued Coverage for the Insured and his/her previously Insured Dependents must be made within thirty (30) days of termination of Coverage. If continuous Coverage is maintained, Coverage may be continued for up to an additional [three (3), six (6), twelve (12)] months. Continuation of Coverage will be subject to the terms of the Policy.

[REINSTATEMENT OF RESERVIST AFTER RELEASE FROM ACTIVE DUTY]

If your insurance or your eligible Dependent's insurance ends due to your being called or ordered to active duty, such insurance will be reinstated without any waiting period when you return to school and satisfy the eligibility requirements defined by the Policyholder.

[ACCIDENTAL DEATH [AND DISMEMBERMENT] BENEFIT]

[Insured Student Only]

If the Eligible Person, within [ninety (90)] [one hundred eighty (180)] [three hundred sixty-five (365)] days from the date of an Accident which occurs while Coverage is in force, dies as the result of Injury from such Accident, We will pay the Eligible Person's beneficiary the amount for Loss of life as shown on the Schedule of Benefits. If the Eligible Person, within [ninety (90)] [one hundred eighty (180)] [three hundred sixty-five (365)] from the date of an Accident, which occurs while Coverage is in force, suffers dismemberment as the result of Injury from such Accident, We will pay the Eligible Person the amount set opposite such Loss, as shown on the Schedule of Benefits. If more than one (1) such Loss is sustained as the result of one (1) Accident, we will pay only one (1) amount the largest to which the Eligible Person or his or her beneficiary would be entitled.

[Any benefit payable under this part will be in addition to any benefit otherwise payable under this Policy.]

[Loss of hand or foot means Loss by severance at or above the wrist or ankle joint. Loss of sight must be entire and irrecoverable. [Loss of a thumb and index fingers means Loss by severance at or above the metacarpophalangeal joints, which are the joints between the fingers and the hand.] Any benefit payable under this part will be in addition to any benefit otherwise payable under this Policy.]

This benefit is subject to all the terms, Conditions and exclusions of this Policy.]

[ACCIDENTAL DEATH [AND DISMEMBERMENT] BENEFIT EXCLUSIONS]

These exclusions are in addition to the General Exclusions. No Benefits are payable for any Loss caused by:

- [Bodily or mental infirmity.]
- [Ptomaine or bacterial infections except:
 - a. Infections which occur simultaneously with or through a cut or wound sustained as the direct result of an Injury, independent of any other cause; and
 - b. The accidental ingestion of a contaminated substance.]
- [Medical or surgical treatment, except Losses that result directly from surgical operations made necessary solely by Injury which is the direct result of an Accident, independent of disease or bodily infirmity or any other cause, and performed within three (3) months of the Accident.]
- [Travel, or flight in or descent from any kind of aircraft unless:
 - a. [As a fare paying passenger on a regularly scheduled flight; or]
 - b. [As a passenger on an official flight of the Military Airlift Command of the United States or similar air transport services of other countries.]]
- [War or any act of war, declared or undeclared.]
- [Being under the influence of alcohol or any drug unless administered and taken as prescribed by a Doctor.]
- [Any accident or occurrence arising out of or in the course of employment.]
- [Participation in an attempt to commit an assault or felony, or participation in a riot.]
- [Suicide or intentionally self-inflicted Injury while sane or insane.]
- [Sickness or its medical or surgical treatment, including diagnosis [; or hernia].]
- [Bacterial infection, except through a wound accidentally sustained.]
- [Voluntary gas inhalation or poison voluntarily taken, administered or inhaled.]
- [Riding or driving as a professional in any kind of race for prize money or profit.]
- [Practicing for, participating in, or traveling as a team member to and from interscholastic, intercollegiate, club, professional and semiprofessional sports, racing or speed contests, scuba diving, skin diving or sky diving, or mountaineering (where ropes or guides are customarily used).]]

[ACCIDENTAL DEATH [AND DISMEMBERMENT] BENEFICIARY INFORMATION]

The Eligible Person's beneficiary is the person or persons who will receive his or her Accidental Death [and Dismemberment] Benefit if the Eligible Person dies.

The Eligible Person will be required to name a beneficiary when he or she enrolls. The Covered Person may later change his or her beneficiary. This change must be made on forms We provide and must be received in our home office. Any change will be effective on the date he or she signs proper forms. We will not be responsible for a change received after his or her claim has been paid. When the beneficiary is changed, any previous choice of beneficiary will be void.

More than one (1) beneficiary may be named. We will pay the amount the Eligible Person specifies for each person. If he or she does not specify amounts, we will divide the benefit equally. If one (1) of the beneficiaries dies before the Covered Person dies, We will divide the benefit equally among the others, unless the Covered Person specifies otherwise.

If the Eligible Person fails to name a beneficiary or if there is no beneficiary surviving when the Covered Person dies, We will, at our option, pay in successive order, the spouse, children, parents, brothers, sisters, or the Eligible Person's estate.

GENERAL EXCLUSIONS AND LIMITATIONS

Unless specifically included, no Benefits will be paid for: a) Loss or expense caused by, contributed to, or resulting from; b) treatment, services, or supplies for, at, or related to:

1. [Eyeglasses, contact lenses, including but not limited to routine eye refractions, eye exams [except as in the case of Injury]. Orthoptic Therapy, visual training or radial keratotomy or similar surgical procedures to correct vision, except as provided herein;]
2. [Hearing Screenings or hearing examinations or hearing aids and the fitting or repairing of hearing aids; [except in the case of Accident or Injury]
3. [Vaccinations, inoculations and preventive shots: a) required for travel; b) required for employment; c) provided as wellness or prevention other than well baby/child [or specifically listed immunizations provided herein]]
4. [Treatment (other than surgery) of chronic Conditions of the foot including, but not limited to, weak or fallen arches, flat or pronated foot ,subluxations of the foot, foot strain, care of corns, calluses, toenails or bunions, any type of massage procedure on or to the foot, corrective shoes, shoe inserts and orthotics;]
5. [Cosmetic surgery, Plastic surgery, resulting complications, consequences and after effects or other services and supplies that We determine to be furnished primarily to improve appearance rather than a physical function or control of organic disease [except as provided herein] [or for treatment of an Injury that is covered under the Policy]. Improvements of physical function does not include improvement of self-esteem, personal concept of body image, or relief of social, emotional, or psychological distress. Procedures not covered include, but are not limited to: face lifts, rhinoplasty, sagging eyelids, prominent ears, skin scars, baldness, and correction of breast size, asymmetry or shape by means of reduction, augmentation, or breast implants (except for correction or deformity resulting from mastectomies or lymph node dissections);]
6. [[Sexual reassignment surgery] [or any treatment of gender identity disorders;]]
7. [Treatment, service, or supply which is not Medically Necessary as determined by Nationwide Life Insurance for the diagnosis, care or treatment of the Sickness or Injury involved. [This applies even if they are prescribed, recommended or approved by the Student Health Center or by the person's Attending Doctor or dentist]]
8. [Treatments which are considered to be unsafe, Experimental, or Investigational by the American Medical Association (AMA), and resulting complications. Upon written request, claims denied under this provision may be reviewed by an independent medical review entity if You or Your Dependent has a terminal Condition that , according to the health care Provider's current diagnosis, has a high probability of causing death within [two years] from the date of the request for medical review.]
9. [Custodial Care;]
10. [Treatment on or to the Teeth or gums (except as provided herein);]
11. [TMJ]
12. [Injury sustained while (a) participating in any [intramural], [intercollegiate], [professional], [semi-professional] or [club sport, contest, or competition]; (b) traveling to or from such sport, contest, or competition as a participant; or (c) while participating in any practice or Conditioning program for such sport, contest, or competition;]

13. [For an Injury sustained by reason of a motor vehicle accident to the extent that Benefits are paid or payable by any other valid and collectible insurance whether or not claim is made for such Benefits;
For Injury resulting from travel in or upon a [snowmobile], [ATV (all terrain or similar type two or three wheeled vehicle and/or off –road four wheeled motorized vehicles,] [personal watercraft,] [parachuting,] [hang gliding,] [skydiving,] [parasailing,] [scuba diving,] [skin diving,] [speed contests,] or [bungee jumping;]]
14. Injury occurring in consequence of riding or otherwise being in any vehicle or device of aerial navigation, except as a fare-paying passenger on a regularly scheduled flight of a commercial airline;
15. [Travel in or upon motor vehicles not primarily designed and licensed for use on public streets or highways;]
16. [Reproductive/Infertility services including but not limited to: fertility tests, infertility (male or female) including any services or supplies rendered for the purpose or with the intent of inducing conception except as specifically provided in this Policy. Examples of fertilization procedures are ovulation induction procedures, in vitro fertilization, embryo transfer or similar procedures that augment or enhance your reproductive ability; artificial insemination; premarital examination; impotence, organic or otherwise; sterilization or sterilization reversal; vasectomy;]
17. [Routine newborn, infant care, well baby nursery and related Doctor charges including circumcision and congenital Conditions, except as specifically provided for in this Policy for newborn or adopted infants;]
18. [Pregnancy that results under a Surrogate Parenting Agreement;]
19. [Elective termination of pregnancy including the morning after pill, plan B;]
20. [Hospital Confinement or any other services or treatment:
That You or Your Dependent(s) are not legally obligated to pay; or
 - a. For which no charge is made.]
21. [Services provided normally without charge by the health service of the Policyholder, or services covered or provided by a Student health fee;]
22. [treatment in a government Hospital, unless there is a legal obligation for the Covered Person to pay for such treatment;]
23. [Any services of a Doctor, Nurse, or Health Care Practitioner who lives with You or Your Dependent(s) or who is related to You or Your Dependent(s) by blood or marriage.]
24. [Expense covered by any other valid and collectible insurance to the extent that Benefits are payable under any other valid and collectible insurance whether or not a claim is made for such Benefits;]
25. [Services received before the Insured's Effective Date [or during an Inpatient stay that began before the Insured's Effective Date.] Services received after the Insured's Coverage ends, except as specifically provided under the Extension of Benefits provision;
 - a. Under the Prescription Drug Benefit, when included, any drug or medicine:
 - b. Obtainable Over the Counter (OTC);
 - c. [Containing nicotine or other smoking deterrent medication;]
 - d. For the treatment of alopecia (hair Loss) or hirsutism (hair removal);
 - e. For the purpose of weight control;
 - f. Anabolic steroids used for body building;
 - g. [For the treatment of infertility;]
 - h. [Birth control of any means], [including plan B or Morning After Pill]
 - i. Sexual enhancement Drugs;
 - j. Cosmetic, including but not limited to, the removal of wrinkles or other natural skin blemishes due to aging or physical maturation, or treatment of acne [except as specifically provided in this Policy];
 - k. [treatment of nail (toe or finger) fungus;]
 - l. Refills in excess of the number specified or dispensed after one (1) year of date of the prescription;
 - m. For an amount that exceeds a [20,30,40,60,90] day supply

- n. Drugs labeled, "Caution – limited by federal law to Investigational use" or Experimental Drugs;
 - o. Purchased after Coverage under the Policy terminates;
 - p. Consumed or administered at the place where it is dispensed;
 - q. If the FDA determines that the drug is:
 - Contraindicated for the treatment of the Condition for which the drug was prescribed; or
 - Experimental for any reason.]
26. [Drugs and medicines when not confined in a Hospital or Skilled Nursing Facility as an Inpatient, except as provided in the Prescription Drug benefit;]
 27. [Vitamins, minerals, food supplements, herbs, herbal Formulas, or home remedies; except as herein provided;]
 28. [Addictions such as [nicotine addiction], caffeine addiction and non-chemicals addictions such as gambling, sexual, spending, shopping, working and religious; and codependency;]
 29. [Testing for [Learning disabilities] or other educational purposes including, but not limited to school placement or progress, psychological or intelligence testing;]
 30. [Vocational recreation, art, dance, poetry, music, or other similar-type therapies, including regression therapy; personal enhancement or self-actualization Therapy;]
 31. [Treatments which do not meet the national standards for mental health professional practice; telephonic consultation, methadone maintenance or treatment; and facilities or homes that provide twenty-four (24) hour non-medical residential care or day care;]
 32. [For Injury caused by, contributed to or resulting from the Covered Person's use of alcohol, illegal drug or use of legal medicines that are not taken in the dosage or for the purposed as prescribed by the Covered Person's Doctor;]
 33. [Injuries sustained as a result of suicide or any attempt at suicide, including drug overdose or intentional/unintentional self-inflicted Injury or any attempt at intentional/unintentional self-inflicted Injury;]
 34. Services for the treatment of any Injury or Illness incurred while committing or attempting to commit a felony; or while taking part in an insurrection or riot; [or fighting, except in self-defense;]
 35. [Any and all over the counter smoking cessation and treatment of nicotine addiction products;]
 36. [Modifications made to dwellings, property, or automobiles such as ramps, elevators, stair lifts, swimming pools, spas, air Conditioners or air-filtering systems, equipment that may increase the value of the residence, or car hand controls, whether or not their installation is for purposes of providing therapy or easy access, or are portable to other locations;]
 37. [Obesity treatment: Services and associated expenses for the treatment of obesity and any resulting complications, consequences and after effects of treatment that involves surgery and any other associated expenses, including, but not limited to:
 - Gastric or intestinal bypasses;
 - Gastric balloons;
 - Stomach stapling;
 - Wiring of the jaw;
 - Panniculectomy;
 - Appetite suppressants;
 - Surgery for removal of excess skin or fat;]
 38. [Injury or Sickness for which Benefits are paid or payable under any workers' compensation or occupation disease law or act, or similar legislation;]
 39. War or any act of war, declared or undeclared; or while in the armed forces of any country;

- 40. [Habilitative physical therapy and occupational or speech therapy;]
- 41. [Nutrition counseling services, genetic counseling and genetic studies;]
- 42. [General fitness, exercise programs, health club memberships and weight loss programs. Exercise machinery or equipment, including but not limited to treadmill, stair steps, trampolines, weights, sports equipment, support braces used primarily for use during any sport or in the course of employment, any equipment obtainable without a Doctor's prescription;]
- 43. [Solid organs, including but not limited to: autologous and allogenic bone marrow transplants, autologous and allogenic stem cell transplants, including non-human organs or bone marrow; Anything caused by, contributed to, or resulting from an organ transplant, including complications thereof;]
- 44. [Treatment received outside of the United States of America, except when Medically Necessary for an Emergency Confinement in a Hospital;]
- 45. [MP Electronic Beam (EBCT) Scan, or "Ultra Fast CT";]
- 46. [Any benefit not listed in this Policy;]

[PRE-EXISTING CONDITIONS LIMITATION]

[There is no Coverage for Pre-existing Conditions unless the Covered Person has had [three (3), six (6), twelve (12)] months of Continuous Coverage.

The Covered Person must provide us proof of prior Creditable Coverage.

Pre existing Conditions in excess of \$[500-2,500] are not covered for the first [three (3), six (6), twelve (12)] months following the Covered Person's Effective Date of Coverage under the Policy.

This limitation will not apply if, during the period immediately preceding the Covered Person's Effective Date of Coverage under this Policy, the Covered Person was covered under prior Creditable Coverage for six (6) consecutive months. Prior Creditable Coverage of less than six (6) months will be credited toward satisfying the Pre-existing Condition limitation. This waiver of Pre-existing Conditions will apply only if the Covered Person becomes eligible and applies for Coverage within sixty-three (63) days of termination of his or her prior Coverage.

[Pregnancy, including Complications of Pregnancy maternity care and genetic disorders, shall not be considered a Pre-existing Condition under the Policy.]

[Pregnancy existing on the Covered Person's Effective Date of Coverage will be considered a pre existing Condition.]

Continuous Coverage: The period of time that a Covered Person is continuously Insured under this Policy and/or any prior Creditable Coverage with no greater than a sixty-three (63) day lapse between the Effective Date of Coverage under this Policy and the termination of prior Creditable Coverage.]

[PRE-CERTIFICATION PROCESS]

[The Schedule of Benefits identifies medical Covered Services which must be Pre-Certified by the Review Organization. Advising the Review Organization before You receive such medical Covered Services allows the Review Organization to determine Medical Necessity and Medical Appropriateness. Medical care that is not necessary and appropriate adds to the cost of care and exposes You to unnecessary risk.

You are responsible for calling the Review Organization at the phone number found on the back of your ID card and starting the Pre-Certification process. For Inpatient services, the call [must] [should] be made [at least five (5) working days] prior to Hospital Confinement. In the case of an Emergency, the call must take place [within two (2) working days of admission] [or] [as soon as reasonably possible].

Pre-Certification is not required for Emergency or Urgent Care.

[Failure to comply with the Pre-Certification process requirements [will] [may] result in a Pre-Certification penalty. Such penalty amount is payable even though Deductible and Coinsurance Maximum Limit amounts have been met. The Pre-Certification penalty is listed in the Schedule of Benefits.]

Your Doctor will be notified of the Review Organization's decision as follows:

- For elective (*non-Emergency*) admissions to a Health Care Facility, the Review Organization will notify Your Doctor and the Health Care Facility by telephone and/or in writing of the number of Inpatient days, if any, approved;
- For Confinement in a Health Care Facility *longer than* the originally approved number of days, Your treating Doctor or the Health Care Facility must contact the Review Organization before the last approved day. The Review Organization will review the request for continued stay to determine Medical Necessity and notify the Doctor or the Health Care Facility of its decision in writing or by telephone;
- [For any other Covered Services requiring Pre-Certification (identified in the schedule of Benefits), the Review Organization will contact the Provider in writing or by telephone regarding its decision;]

Our Review Organization agent will make this determination within seventy-two (72) hours for an urgent request and four (4) business days for non urgent requests following receipt of all necessary information for review. Notice of an adverse determination made by the Review Organization agent will be in writing and will include:

- The reasons for the adverse determination including the clinical rationale, if any.
- Instructions on how to initiate standard or urgent appeal.
- Notice of the availability, upon request of the Covered Person, or the Covered Person's designee, of the clinical review criteria relied upon to make the adverse determination. This notice will specify what, if any additional necessary information must be provided to, or obtained by, the Review Organization Agent in order to render a decision on any requested appeal.

Failure by the Review Organization agent to make a determination within the time periods prescribed shall be deemed to be an adverse determination subject to appeal.

If You have questions about Your Pre-Certification status, You should contact Your Provider.]

[PRE-ADMISSION NOTIFICATION]

Pre-Notification of Medical Non-Emergency Hospitalizations:

The Covered Person, Doctor or Hospital should call the toll free telephone number on the back of the Identification Card at least five (5) working days prior to the planned admission.

Notification of Medical Emergency Admissions:

The Covered Person, Doctor, Covered Person's representative, or Hospital should call the toll free telephone number on the back of the ID card within two (2) working days of the admission to provide notification of any admission due to Medical Emergency.

[Important: Failure to follow the notification procedure will not affect Benefits otherwise payable under the Policy. However, failure to follow the pre-notification procedures will result in the Pre-Notification penalty listed in the Schedule of Benefits. Pre-notification is not a guarantee that Benefits will be paid.]

[PREFERRED PROVIDER BENEFIT]

We encourage Covered Persons to use Preferred Providers by providing benefit incentives when Preferred Providers are used.

In the event of an Emergency Admission, services rendered by any Hospital due to and within the first twenty-four (24) hours after the onset of the Emergency are covered as if the service had been provided by a Preferred Hospital.

In the case of a Medical Emergency, if outside of a [twenty-five (25)-fifty (50)]-mile radius of the [Student Health Center (SHC)] and/or [In-Network Provider] and an Out-of-Network Provider are used, the In-Network percentage in the Schedule of Benefits will be applied.

A Covered Person is not required to seek treatment from a Preferred Provider. Each Covered Person is free to elect the services of a Provider and Benefits payable will be made in accordance with the terms and Conditions of this benefit.

We do not make any representation or warranty as to the medical competence or ability of a Preferred Provider or to their respective staff or Doctors. We shall not have any liability or responsibility, direct, indirect, vicarious or otherwise, for any actions or inactions, whether negligent or otherwise, of the Preferred Provider, their staff or Doctors.

Out-of-Network Provider: Any Hospital or Doctor that is not a member of the Preferred Provider network arrangement that has contracted with Us.

Preferred Provider: Any Hospital or Doctor that has contracted with Us to provide services, as described in this Policy, through a Preferred Provider network arrangement, to be reimbursed at discounted fees.

[If you are undergoing an active course of treatment with a preferred Provider for an acute Condition, a serious chronic Condition, a pregnancy, a terminal Illness, the care of a newborn child between birth and age thirty-six (36) months or performance of a surgery or other procedure that has been recommended and documented by the preferred Provider to occur within one hundred eighty (180) days of the Preferred Provider's contract termination date, you may request continuation of treatment by such Preferred Provider in the event the Preferred Provider's contract has terminated with the Preferred Provider Organization.

- An acute Condition is a medical Condition that involves a sudden onset of symptoms due to an Illness, Injury, or other medical problem that requires prompt medical attention and that has a limited duration. Completion of Covered Services shall be provided for the duration of the acute Condition or until the Covered Person's Coverage terminated, whichever occurs first.
- A serious chronic Condition is a medical Condition due to a disease, Illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration. Completion of Covered Services shall be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another Provider, as determined by the health insurer in consultation with the Insured and the terminated preferred Provider and consistent with good professional practice. Completion of Covered Services under this paragraph shall not exceed twelve (12) months from the preferred Provider's contract termination date or until the Covered Person's Coverage terminated, whichever occurs first.
- A pregnancy is the three trimesters of pregnancy and the immediate postpartum period. Completion of Covered Services shall be provided for the duration of the pregnancy or until the Covered Person's Coverage terminated, whichever occurs first.
- A terminal Illness is an incurable or irreversible Condition that has a high probability of causing death within one or two years or less. Completion of Covered Services shall be provided for the duration of a terminal Illness or until the Covered Person's Coverage terminated, whichever occurs first.
- The care of a newborn child between birth and age thirty-six (36) months will not exceed twelve (12) months from the preferred Provider's contract termination date.]

STUDENT HEALTH SERVICES REFERRAL

The Student must first seek services of the Student Health Center (SHC). If the SHC cannot provide the service needed, the Student must obtain an initial referral that verifies that the services were not available at the SHC. The Student is then free to seek services without penalty with a Provider outside of the SHC. Expenses incurred for treatment rendered outside of the SHC for which no referral is obtained will be excluded from Coverage.

A SHC referral for outside care is necessary except under the following Conditions:

- Medical Emergency;
- When the SHC is closed [for four (4) or more continuous days] due to official holidays or breaks;
- Medical care received when the Student is more than [twenty five (25)- fifty (50)] miles from campus;
- Medical care obtained when the Student is no longer able to use the SHC due to change in Student status;
or
- Maternity.

A written referral from the SHC is required for any follow-up care, with a Provider other than SHC, after Emergency services.

[Each written referral for a Condition is valid for ninety (90) days unless a greater time period is indicated on the referral form.]

A SHC referral does not constitute a guarantee of Benefits when treatment is provided outside the SHC. We reserve the right to determine the Medical Necessity of treatment for services provided outside the SHC.

[Dependents are not eligible to use the SHC, and therefore, are exempt from the SHC referral requirement.]

[COORDINATION OF BENEFITS]

Read this section with care. It applies to all sections of the Policy that pay Benefits for Covered Charges except the Prescription Drug Benefit if it is contained in this Policy.

The intent of this section is to help control Your Premium costs by preventing financial gain by persons Insured under more than one plan. All plans will be taken into account for this section, even plans, which do not have a co-ordination of Benefits provision.

Benefits received from this Policy are coordinated with Benefits, which the Covered Person may receive from certain other plans. The Covered Person is urged to file any claims as early as possible with all insurance companies under which he or she has health Coverage. This will help Us to provide the Maximum Benefit due as soon as possible.

The total benefit received from all plans may not exceed 100% of Allowable expenses.

DEFINITIONS APPLICABLE TO COORDINATION OF BENEFITS SECTION:

"Covered Person" means the person for whom a claim is being made.

"plan" means any plan that provides Benefits or services for or by reason of medical or dental care or treatment. These are:

1. Group, blanket, or franchise insurance Coverage whether Insured or unInsured but not including:
 - A contract covering elementary, junior high, high school and or college Students for accidents only, including athletic injuries, on a twenty-four hour basis or on a "to and from school" basis; or
 - Hospital indemnity Benefits of \$100 per day or less so long as they are the indemnity-type benefit as opposed to the reimbursement-type benefit. (Any amount of Hospital indemnity Benefits of either type which exceed \$100 per day will be included); or
2. Group or group-type Coverage through health maintenance organizations, Hospital or medical service organizations, group practice and other prepayment Coverage; or
3. Labor-management trustee plans, union welfare plans and employer or employee Benefit plans; or
4. Any Coverage required or provided by a government except Medicaid; or
5. No-fault vehicle insurance.

"This Policy" means the sections of this Policy that pay Benefits for Covered Charges.

"Allowable expenses" means any needed, reasonable item of expense which is at least partly covered under one of the plans covering the Covered Person.

When Benefits are reduced under the primary plan because the Covered Person did not comply with the plan provisions, the amount of such reduction will not be considered an Allowable expense. However, the secondary plan cannot refuse to pay Benefits because a Health Maintenance Organization (HMO) member has elected to have health care services provided by a non-HMO Provider and the HMO, pursuant to its contract, is not obligated to pay for providing those services. When a plan provides services rather than cash payments, the reasonable cash value of the service will be considered as both an Allowable expense and a Benefit paid.

EFFECT ON BENEFITS:

The Policy Year is the basis for consideration of claims. This provision will be used when the Benefits the Covered Person would receive under this Policy plus those received under all other plans would exceed the total Allowable expense. If the Benefits provided under all plans exceed the Allowable expense, We will reduce our Benefits so that the total is not exceeded. However, if the Covered Person is Insured under another plan containing a co-ordination of Benefits provision, the following rules will be used to determine which plan may reduce Benefits.

1. That plan which insures the Covered Person as an employee (that is, other than as a Dependent) are determined before those of the plan which covers the Covered Person as a Dependent, except that, if the Covered Person is also a Medicare beneficiary, and as a result of the rules established by Title XVIII of the Social Security Act and implementing regulations, Medicare is:
 - Secondary to the plan covering the person as a Dependent; and
 - (Primary to the plan covering the person as other than a Dependent, then the Benefits of the plan covering the person as a Dependent are determined before those of the plan covering that person as other than a Dependent.
2. The Benefits of a plan which insures the Covered Person as a Dependent child of a person whose date of birth, excluding the year of birth, occurs earlier in the calendar year, shall be determined before the Benefits of a plan which covers such person as a Dependent of a person whose date of birth, excluding the year of birth, occurs later in the calendar year. If both such persons have the same date of birth, the Benefits of the plan of the person who has been Insured under his or her plan for the longer period of time shall be determined first. If the other plan does not have the provisions of this paragraph regarding Dependents, which results in the plans not agreeing on the order of Benefits, the rule set forth in the other plan will determine the order of Benefits.

However, if the Covered Person is a Dependent child with separated or divorced parents, Benefits for the child are determined in this order:

- First, the plan of the parent with custody of the Dependent child;
- Then the plan of the spouse of the parent with custody of the Dependent child; and
- Finally the plan of the parent not having custody of the Dependent child.

However, if there is a court decree, which gives financial responsibility to a particular parent for the health care expenses of the child, statements above do not apply. In this case, any other plan, which covers the child as a Dependent may reduce before the plan which, covers the child as a Dependent of the parent with financial responsibility.

3. If a court decree states that the parents share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the Dependent child shall follow the order of Benefits set forth in rule two (2).
4. The Benefits of a plan which covers a person as an employee who is neither laid-off nor retired (or as that employee's Dependent) are determined before those of a plan which covers that person as a laid-off or retired employee (or as that employee's Dependent). If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of Benefits, this rule four (4) is to be ignored.
5. Continuation Coverage. If a person whose Coverage is provided under a right of continuation pursuant to federal law, namely COBRA, or state law, also is covered under another plan, Benefits are determined in the following order:
 - First, the Benefits of the plan covering the person as an employee (or as that employee's Dependent);
 - Second, the Benefits under the continuation of Coverage.If the other plan does not have this rule and if, as a result, the plans do not agree on the order of Benefits, this rule (5) shall be ignored.

6. When none of the rules above determines the order of Benefits, the plan that has Insured the Covered Person for a shorter period of time may reduce Benefits if another plan has Insured that Covered Person for a longer period of time.

If Benefits are reduced under this section and later in the same Policy Year the total Allowable expense exceeds the Benefits paid under all plans, We will pay additional Benefits. These Benefits will not exceed the lesser of:

- The amount of the earlier reduction; or
- The amount which would cause total Benefits under all plans to exceed total Allowable expenses.

If the total amount of benefit is reduced under this section, each benefit will be reduced proportionately and only the reduced amount will be charged against each benefit limit.

RIGHT TO RECEIVE AND RELEASE INFORMATION:

To carry out this provision:

- The Covered Person must furnish to Us any necessary information; and
- We may, without asking for consent, obtain necessary information from any source; and
- We may release information to other plans.

FACILITY OF PAYMENT/RIGHT OF RECOVERY:

If another plan pays an amount that this Policy should have paid, We have the right to pay the benefit to that plan. This ends Our duty for payment of that claim. If this Policy pays an amount that another plan should have paid, We have the right to recover the excess amount from the person or organization to whom it was paid.

[CLAIM PROVISIONS]

Notice of Claim: Written Notice of Claim must be given to Us or Our authorized representative within [sixty (60), ninety (90)] days after a covered Loss starts, or as soon thereafter as is reasonably possible. Notice should include information sufficient to identify the Covered Person.

Claim Forms: Upon Our receipt of written Notice of Claim, We will furnish to the claimant such forms as are usually furnished by Us for filing Proofs of Loss. If such forms are not furnished within [fifteen (15)- ninety (90)] days after the giving of such notice, the claimant shall be deemed to have complied with the requirements of this Policy as to Proof of Loss upon submitting, within the time fixed in this Policy for filing Proof of Loss, written proof covering the occurrence, the character, and the extent of the Loss for which claim is made.

Proof of Loss: If it is necessary to file a claim, a written claim form must be given to Us within ninety (90) days of such claim. If it was not possible for the claim form to be given within ninety (90) days, We will not deny the claim because of late filing, provided proof was given as soon as reasonably possible. In any case, the claim form must be sent no later than one (1) year from the date of service, unless the Covered Person is legally incapacitated.

Time of Payment of Claims: Benefits payable under this Policy for any Loss, other than Loss for which this Policy provides any periodic payment, will be paid immediately upon, or within thirty (30) days after, receipt of due written proof of such Loss. Subject to due written proof of Loss, all accrued indemnities for Loss for which this Policy provides periodic payment will be paid monthly and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.

[Use if no AD&D benefit]

Payment of Claims: Benefits will be payable to the Covered Person or the medical services Provider if We have received a valid assignment by the Covered Person.

If any indemnity of this Policy shall be payable to the estate of the Covered Person or to a Covered Person who is a minor or otherwise not competent to give a valid release, We may pay such indemnity to his parent, guardian or other person actually supporting him. Any payment made by Us in good faith pursuant to this provision shall fully discharge Us to the extent of such payment.

Subject to any written direction of the Covered Person or of the legal or natural guardian of the Covered Person, if the Covered Person is a minor or otherwise incompetent to make such a direction, all or a portion of any indemnities provided by the Policy as a result of medical, surgical, dental, Hospital or nursing service may, at Our option, and unless We are requested in writing not later than the time for filing Proofs of Loss, be paid directly to the Hospital or person rendering such services; but it is not requested that the services be rendered by a particular Hospital or person.

[Use if AD&D benefit provided]

Payment of Claims: Unless instructed by You otherwise, Benefits payable under this Policy for Loss of life are payable to the first surviving classes of the Covered Person: spouse; child or children; mother or father; sisters or brothers; or estate. All other Benefits will be payable to the Covered Person or the medical services Provider if We have received a valid assignment by the Covered Person.

If any indemnity of this Policy shall be payable to the estate of the Covered Person or to a Covered Person who is a minor or otherwise not competent to give a valid release, We may pay such indemnity to his parent, guardian or other person actually supporting him. Any payment made by Us in good faith pursuant to this provision shall fully discharge Us to the extent of such payment.

Subject to any written direction of the Covered Person or of the legal or natural guardian of the Covered Person, if the Covered Person is a minor or otherwise incompetent to make such a direction, all or a portion of any indemnities provided by the Policy as a result of medical, surgical, dental, Hospital or nursing service may, at Our option, and unless We are requested in writing not later than the time for filing Proofs of Loss, be paid directly to the Hospital or person rendering such services; but it is not requested that the services be rendered by a particular Hospital or person.

Physical Examination and Autopsy: We, at Our own expense, shall have the right and opportunity to examine the Covered Person as it may reasonably require while a claim is pending. We, at Our own expense, may also have the right to make an autopsy in the case of death, where it is not prohibited by law.

Physical Examination: We, at Our own expense, shall have the right and opportunity to examine the Covered Person as it may reasonably require while a claim is pending.

Legal Actions: A legal action may not be brought to recover on this Policy within sixty (60) days after written Proof of Loss has been given as required. No such action may be brought after three (3) years from the time written proof was required to be given.

[MEDICAL NECESSITY and MEDICAL APPROPRIATENESS DETERMINATION]

We reserve the right to review claims and establish standards and criteria to determine if a Covered Service is Medically Necessary and Medically Appropriate. Benefits will be denied by Us for Covered Services that are not Medically Necessary and Medically Appropriate. In the event of such a denial, You will have to pay the entire amount billed by that Provider. You do have the right to appeal any adverse decision as outlined in the Appeals and Compliant Section of this Policy. [You may have the right to an external independent review as outlined in the Appeals and Compliant Section of this Policy.]

Covered Services are Medically Necessary if they are:

- Required to meet the health care needs of the Covered Person; and
- Consistent (in scope, duration, intensity and frequency of treatment) with current scientifically based guidelines of national medical or research organizations or governmental agencies; and
- Consistent with the diagnosis of the Condition; and
- Required for reasons other than the comfort or convenience of the Covered Person or Provider; and
- Of demonstrated medical value and medical effectiveness.

A Covered Service is Medically Appropriate if it is rendered in the most cost-effective manner and type of setting appropriate for the care and treatment of the Condition.

If You have any questions or concerns about whether a particular service, supply, or treatment is Medically Necessary or Medically Appropriate, contact Us.

[GENERAL PROVISIONS]

Entire Contract; Changes: The Policy, including the Certificate, if any, endorsements and the attached papers, if any, constitutes the entire contract of insurance. No change in the Policy shall be valid until approved by one of Our executive officers and unless such approval is endorsed hereon or attached hereto. No agent has authority to change the Policy or waive any of its provisions.

Failure by Us to enforce any Policy provision shall not waive, modify or render such provision unenforceable at any other time; at any given time; or under any given set of circumstances, whether the circumstances are or are not the same.

We have full, exclusive and discretionary authority to determine all questions arising in connection with the Policy, including its interpretation.

Grace period: A grace period of thirty-one (31) days will be granted for the payment of Premiums accruing after the first Premium, during which grace period the Policy shall continue in force, but the Covered Person shall be liable to Us for the payment of the Premium accruing for the period the Policy continues in force.

Incontestability: All statements made in an application by the Policyholder are, in the absence of fraud, representations and not warranties. No statement shall be used to contest the Policy, the validity of Coverage or reduce Benefits, unless it is in writing, signed by the Policyholder, and a copy of such statement is furnished to the Policyholder.

Non-Participating: The Policy is non-participating. It does not share in Our profits or surplus earnings.

Conformity with State Statutes: If any provision of this Policy is contrary to any law to which it is subject, such provision is hereby amended to conform to the minimum requirements of such law.

Workers' Compensation: This Policy is not in lieu of and does not affect any requirement for Coverage by Workers' Compensation Insurance.

Clerical Error: If a clerical error is made so that an otherwise Eligible Person's Coverage does not become effective, Coverage may be in effect if: (a) the Policyholder makes a written request for Coverage on a form approved by Us ; and (b) any Premium not paid because of the error is paid in full from the Effective Date of Coverage. Company reserves the right to limit retroactive Coverage to two months preceding the date the error was reported.

If a clerical error is made so that the Coverage is in effect for a person who is not eligible, an adjustment will be made to correct the error. Any Premium refund will be reduced by any payment made for claims. If claims paid exceed the Premium refund, the Policyholder shall reimburse Us for the overpayment.

Information and Records: We shall have the right to inspect, at reasonable times, any of the Policyholder's records for the Policy. The Policyholder shall provide Us with information necessary to administer Coverage and set Premium under the Policy. Information is required when an Eligible Person becomes covered, when changes in amounts of Coverage occur, and when a Covered Person's Coverage terminates.

[SUBROGATION AND RECOVERY RIGHTS]

Right of Recovery: If the amount of the payment made by Us is more than We should have paid under this Policy, We may recover the excess from one or more of: (a) The person we have paid; (b) The person for whom We have paid; (c) Insurance companies or any other plan; or (d) other organization. The amount of the payments made includes the reasonable cash value of any benefit provided in the form of services.

Right to Subrogation: If the Insured suffers an Injury or Sickness through the act or omission of another person, and if Benefits are paid under this Policy due to such Injury or Sickness, then We will be entitled to a refund of all Benefits We have paid from such recovery, as permitted by law. The refund of Benefits shall be allowable to the extent the Insured recovers or may recover for the same Injury or Sickness from another plan, including a third party, its insurer, or the Insured's uninsured motorist insurance. Further, We have the right to offset subsequent Benefits payable to the Insured under the Policy against such recovery.

Upon our request, the Insured must complete the required forms and return them to Us or to Our administrator. The Insured must notify Us of any pending or contemplated claims against third parties. The Insured must cooperate fully with Us in asserting a right to recover. The Insured will be personally liable for reimbursement to Us to the extent of any recovery obtained by the Insured from any third party. If it is necessary for Us to institute legal action against the Insured for failure to repay Us, the Insured will be personally liable for all costs of collection, including reasonable attorney's fees.

We may file a lien in an Insured's action against the third party and have a lien upon any recovery that the Insured receives whether by settlement, judgment, or otherwise, and regardless of how such funds are designated. We shall have the right to recovery of the full amount of Benefits paid under the Policy for the Injury or Sickness, and that amount shall be deducted first from any recovery made by the Insured. We will not be responsible for the Insured's attorney's fees or other costs.

Right to Reimbursement: If Benefits are paid under this plan and any person recovers from a third party by settlement, judgment or by operation of primary Coverage, We have a right to recover from that person an amount equal to the amount We paid. However, We will reimburse the Covered Person from any charges on a pro-rata basis for any expense Incurred in securing the settlement, judgment or otherwise.

Limitation to Our Recovery Rights: We may exercise Our Right to Subrogation against third parties unless We are precluded from enforcing such right where a responsible third party has extinguished its liability or has been relieved of liability by contract or operation of law. If We are precluded from exercising Our Right to Subrogation, We may exercise our Right to Reimbursement.

We, in exercising Our Right to Subrogation, will not seek to recover more than We paid under this plan. We, in exercising Our Right to Reimbursement, will not seek to recover more than the amount recovered from a third party.

[EXCESS PROVISION]

[Except for Student Health Center-generated expenses for laboratory and Prescription Drug expenses,]Our liability for medical expense Benefits payable on account of Covered Charges incurred [resulting from Hospital Confinement or surgery] shall be limited to that part of the expense, if any, which is in excess of the total Benefits payable for the same Sickness or Injury, on a provision of service basis or on an expense Incurred basis under any Other Medical Insurance. If Other Medical Insurance provides Benefits on an excess insurance or an excess Coverage basis, [Benefits will be paid first by the insurer or services plan whose Policy or service contract has been in effect for the longer period of time at the date of such Sickness or Injury.] [We will pay a maximum of fifty (50%) of the Benefits otherwise payable.]

[Covered Charges incurred for treatment rendered by the Policyholder's Student Health Service will be administered on a primary basis.]

For purposes of the Policy, a Covered Person's entitlement to Other Medical Insurance will be determined as if the Policy did not exist and shall not depend upon whether timely application for Benefits from Other Medical Insurance is made by or on behalf of the Covered Person.

[Primary Benefit Amount: If a Primary Benefit Amount is shown in the Schedule of Benefits, We will pay the Covered Charges incurred for a Sickness or Injury up to the Primary Benefit Amount. Such Covered Charges will be paid according to the terms of the Policy. Subsequent claims received for the same Sickness or Injury which are in excess of the Primary Benefit Amount, will subject the entire claim to the Excess Provision.]

Other Medical Insurance: Any reimbursement for or recovery of any element of Covered Charges, incurred available from any other source whatsoever, except gifts and donations, but including without limitation:

- Any individual, group, blanket, or franchise Policy of accident, disability or health insurance.
- Any arrangement of Benefits for members of a group, whether Insured or uninsured.
- Any prepaid service arrangement such as Blue Cross or Blue Shield; individual or group practice plans, or health maintenance organizations.
- Any amount payable for Hospital, medical or other health services for accidental bodily Injury arising out of a motor vehicle accident to the extent such Benefits are payable under any medical expense payment provision (by whatever terminology used including such Benefits mandated by law) of any motor vehicle insurance Policy.
- Any amount payable for services or injuries or diseases related to the Covered Person's job to the extent that he actually received Benefits under a Worker's Compensation Law. If the Covered Person enters into a settlement to give up his rights to recover future medical expenses that would have been payable except for that settlement.
- Social Security Disability Benefits, except that Other Medical Insurance shall not include any increase in Social Security Disability Benefits payable to a Covered Person after he becomes disabled while insured hereunder.
- Any Benefits payable under any program provided or sponsored solely or primarily by any governmental agency or subdivision or through operation of law or regulation.
- Any Policy containing Coverage which provides Benefits for medical expenses on a 1st or 3rd party basis.

[COMPLAINT AND APPEAL PROCESS]

Complaint Resolution

1. Administrative Complaints

Complaints due to the denial of services or payment of a claim must be reported no later than [twelve (12), eighteen (18)] months from the date of service. Most complaints can be resolved by calling, or writing to, Our Customer Service Department. The telephone number and address are on Your Identification Card.

If an informal review does not resolve the reported complaint, You will be notified of Your right to appeal.

2. Quality of Care or Service Complaint

Quality of care complaints will be forwarded to the unit responsible for such investigations immediately upon receipt by Customer Service. We will send You a written acknowledgment within [three (3), five (5), ten (10), fifteen (15)] working days of receipt of the complaint. All quality of care complaints will be investigated and corrective action taken where problems and/or deficiencies are verified.

3. If We cannot provide You with a satisfactory solution to Your complaint, You may file a standard or urgent (if applicable) appeal for internal review by contacting Us at the address or phone number on the back of your ID card or write to or call the Department of Insurance, whose information is located in the Important Notice section of this Policy.

4. If We deny a claim as “not Medically Necessary” and cannot provide You with a satisfactory solution to Your complaint, You may request an Independent Medical Review (IMR) by writing to or calling Us [or the Department of Insurance, whose information is located in the Important Notice section of this Policy].

Internal Appeal Review

1. Standard Appeals

You, an authorized person, or a Provider, with Your consent, may submit a written appeal to Us if Coverage is denied, reduced or terminated. The appeal must be requested no later than [sixty (60), ninety (90), one hundred eighty (180), or three hundred sixty (360)] calendar days from the date of receipt of the denial letter.

The appeals staff will review all of the information. A decision will be made within thirty (30) calendar days of receipt for a Pre-Service Claim Appeal and within [forty (40), sixty (60)] calendar days of receipt for a Post-Service Claim Appeal. This time period may be extended for up to an additional sixty (60) calendar days if additional information is needed. You will be notified in writing of the Appeals Department's decision. If the appeal involves a medical necessity determination, an independent peer reviewer, who is in the same or a similar specialty, as the Provider who will perform or performed the service will review the file.

A Pre-Service Claims Appeal is an appeal of any claim for Benefits under the terms of the Policy, which must be Pre-Certified (in whole or in part) before medical care is obtained.

A Post-Service Claims Appeal is an appeal of a decision to deny or reduce Benefits for claim that has already been incurred.

2. Urgent Appeals

You, an authorized person or a Provider, with Your consent, may request an Urgent Appeal. This request may be verbal or written. A decision will be made within seventy-two (72) hours of receipt for an Urgent Appeal.

An Urgent Appeal is an appeal for which the medical Condition, in the absence of immediate medical attention, may result in serious impairment to bodily functions, serious dysfunction of any bodily organ or part, severe pain that cannot be managed adequately, or places in serious jeopardy the health of an individual, and with respect to a pregnant woman, includes her unborn child.

External Appeal Process

After exhausting the Internal Appeal Process, You, an authorized person or a Provider, with Your consent, may request a review from an external independent entity as described below.

1. Department of Insurance Review - Coverage Decision Denials

If We deny Benefits because the service is not a Covered Service, a review of the Coverage Decision may be requested by contacting the:

Department of Insurance at the address located in the Important Notice section of this Policy.

2. [Independent Medical Review –Medical Necessity Denials

You may request an Independent Medical Review (IMR) of medical necessity denial from the Department of Insurance if You believe that We have improperly denied, modified, or delayed health care services. A medical necessity denial is any health care service eligible for Coverage and payment under the Policy that has been denied, modified, or delayed by Us, in whole or in part, because the health care service is not Medically Necessary.

The IMR process is in addition to any other procedures or remedies that may be available to You. You pay no fees of any kind for IMR. You have the right to provide information in support of the request for IMR. You may contact the Department of Insurance for an IMR application or Customer Service for assistance.]

Eligibility:

The Department of Insurance will review Your application for IMR if it is filed within [one (1), two (2), three (3), four (4), five (5), six (6)] months of any of the following qualifying periods or events. All of the following Conditions must be met:

- a. Your Provider has recommended a health care service as Medically Necessary; or
- b. You have received Urgent Care or Emergency services that a Provider determined was Medically Necessary; or
- c. In the absence of (a) or (b) You have been seen by a Participating Provider for the diagnosis or treatment of the medical Condition for which You seek independent review; and
 - The claim has been denied, modified, or delayed by Us based in whole or in part on a decision that the health care service is not Medically Necessary; and
 - You have filed an appeal with Us and the disputed decision is upheld or the appeal remains unresolved after thirty (30) days. If Your appeal requires expedited review You may bring it immediately to the Department of Insurance's attention. The Department of Insurance may waive the requirement that You follow the appeal process in unusual cases.

If Your case is eligible for an IMR, the dispute will be submitted to an IMR organization that will make an independent determination of whether or not the care is Medically Necessary. You will receive a copy of the assessment made by the independent reviewer. If the IMR determines the service is Medically Necessary, We will provide Benefits for the health care service.

For non-urgent cases, the IMR organization, independent of the Company, and/or designated by the Department of Insurance must provide its determination within thirty (30) days of receipt of Your application and supporting documents. For urgent cases involving an imminent and serious threat to Your health, including, but not limited to, serious pain, the potential Loss of life, limb, or major bodily function, or the immediate and serious deterioration of Your health, the IMR organization must provide its determination within three (3) business days.

Please call Our Customer Service Department at the phone # on the back of your Identification Card if You have any questions or need additional information.]

3. Independent Medical Review (IMR) - Experimental or Investigational Denials

Eligibility:

You may request an Independent Medical Review (IMR) from an organization independent of the Company [or designated by the Department of Insurance] if all of the following criteria are met:

- a. You have a Life Threatening or Seriously Debilitating Condition, as certified by Your Doctor.
 - (i) "Life Threatening" means either or both of the following:
 - Diseases or Conditions where the likelihood of death is high unless the course of the disease is interrupted;
 - Diseases or Conditions with potentially fatal outcomes, where the end point of clinical intervention is survival.
 - (ii) "Seriously Debilitating Condition" means diseases or Conditions that cause major irreversible morbidity.
- b. Your Doctor certifies that one of the following situations applies:
 - standard therapies have not been effective in improving the Condition;
 - standard therapies are not Medically Necessary for You;
 - there is no standard therapy covered under the Policy that will benefit You more than the requested therapy;
- c. Your Doctor has recommended a drug, device, procedure or other therapy that he or she certifies in writing is likely to benefit You more than standard therapies; or You or Your Doctor have requested a therapy that based on two (2) documents from the Medical and Scientific Evidence as defined below, is likely to be more beneficial for You than any available standard therapy.
- d. The Doctor's certification includes a statement of the evidence relied upon when certifying the recommendation. We will not pay for services of a Non-Participating Provider that are not otherwise covered.
- e. You have been denied Benefits/Covered Services for services requested in (2) above, unless Coverage for the specific therapy is excluded by this Policy;
- f. The drug, device, procedure or other therapy would be covered under the Policy if it were not considered to be Experimental or Investigational.

For the purposes of this section, "Medical and Scientific Evidence" means the following sources:

1. Peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff.
2. Peer-reviewed literature, biomedical compendia and other medical literature that meet the criteria of the National Institute of Health's National Library of Medicine for indexing in Index Medicus, Excerpta Medicus (EMBASE), Medline and MEDLARS database Health services Technology Assessment Research (HSTAR).

3. Medical journals recognized by the Secretary of Health and Human services, under Section 1861(t) (2) of the Social Security Act.
4. The following standard reference compendia: The American Hospital Formulary Service-Drug Information, the American Medical Association Drug Evaluation, the American Dental Association Accepted Dental Therapeutics and The United States Pharmacopoeia-Drug Information.
5. Findings, studies or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes, including the Federal Agency for Health Care Policy and Research, National Institutes of Health, National Cancer Institute, National Academy of Sciences, Health Care Financing Administration, Congressional Office of Technology Assessment, and any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health services.
6. Peer-reviewed abstracts accepted for presentation at major medical association meetings.

Requesting an Independent Review:

1. Within five (5) business days of Our decision to deny, delay or modify treatment that is Experimental or Investigational therapy, We will notify You, in writing, and include your appeal rights, which include your right to appeal to the Department of Insurance. [You may request an Independent Medical Review (IMR) by writing to or calling the Department of Insurance, whose information is located in the Important Notice section of this Policy.]
2. The panel of experts, supplied by the Independent Medical Review agency, will complete its review within thirty (30) calendar days of receiving the request for review. If Your Provider certifies, in writing, that an imminent and serious threat to Your health may exist the review will be expedited and completed within three (3) days of the request for the expedited review.
3. The Independent Medical Review panel of experts will provide [the Department of Insurance], the Company, You and Your Doctor with copies of the review upon completion of the review and analysis. [The Department of Insurance will immediately adopt the decision of the Independent Medical Review agency and will issue a written decision to all concerned parties.]

There is no expense to You for the Independent Medical Review.

MANDATED BENEFITS

Newborn Infant Coverage

Coverage for tests for hypothyroidism, phenylketonuria, galactosemia, sickle-cell anemia, and all other disorders of metabolism for which screening is performed by or for the State of Arkansas.

Coverage to pay for routine nursery care and pediatric charges for a well newborn child for up to five (5) full days in a hospital nursery or until the mother is discharged from the hospital following the birth of the child, whichever is the lesser period of time.

IMPORTANT NOTICE

NATIONWIDE LIFE INSURANCE COMPANY
NATIONWIDE SPECIALTY HEALTH DEPARTMENT
[TPA ADDRESS]
[TPA PHONE NUMBER]

If you continue to remain unsatisfied, You may contact the [----- Department of Insurance] with any complaint. To contact the Department of Insurance, You may write or call them at:

Arkansas Insurance Department
[1200 West Third Street
Little Rock, AR 72201-1904
(501) 371-2640]



Nationwide Life Insurance Company

Home Office: Columbus, Ohio

[ABC University] Student Accident & Sickness Insurance Enrollment Form

A. PERSONAL INFORMATION (Please Print)

Doe, John	123-45-6789	M / F	1/1/75	<input type="checkbox"/> Non –Funded Graduate <input type="checkbox"/> Funded Graduate ¹
LAST NAME, FIRST NAME, MIDDLE INITIAL	SOCIAL SECURITY NUMBER	SEX – Circle One	Date of Birth	Status – Check one
1234 Any Street, Any City, ST, 12345				
HOME ADDRESS – Street, City, State, Zip Code				
myemail@email.com				
E-mail address				

B. OTHER COVERAGE INFORMATION

Are you or any family members covered by other health insurance? (circle one)		YES / NO	If Yes, please
complete the following:			
Name of Insurance Company		Address of where claims are submitted to:	Is this an Employer Policy? YES / NO
			If Yes, Employer Name: Student / Spouse / Child(ren)
Name of Policyholder	Policy Identification Number	Effective date of Policy	Who is covered? Circle all that are applicable

C. INDIVIDUALS TO BE COVERED

Eligible Dependents Definition: Dependents must be born to you or your spouse or legally adopted, under age of 19 and unmarried, and dependent on you for support as defined by the Internal Revenue Service (IRS)

Spouse's First Name	M.I.	Spouse's Last Name – if different	Date of Birth	Spouse's Social Security Number
Jane	D		2/2/76	987-65-4321
Dependent's First Name	M.I.	Dependent's Last Name – if different	Date of Birth	Dependent's Social Security Number
Jill	M		3/1/01	154-78-6589
Dependent's First Name	M.I.	Dependent's Last Name – if different	Date of Birth	Dependent's Social Security Number

D. TERMS OF AGREEMENT

- * My application is subject to acceptance by Nationwide Life Insurance Company. Information provided will be used only to issue the certificate of coverage and to pay claims. Information collected pursuant to this application will be valid for no longer than 30 months from the date this authorization is signed. Authorizations relating to a claim will remain in effect for the duration of the term of the policy.
- * I authorize any physician, hospital and or any other health care provider to release information available to them as to diagnosis, treatment or any other health care services they render to me or my covered dependents to the Nationwide Life Insurance Company or their legal representatives. I also authorize Nationwide Life Insurance Company to release appropriate diagnostic and medical information to other persons in connection with a claim for coordination of benefits or other purposes related to this contract.
- * I am being offered Blanket Accident and Sickness insurance from the Nationwide Life Insurance Company and have chosen the plan appropriate for my needs.
- * I understand that if my application is accepted my coverage will end on the end date which I select and I will be responsible for any continued coverage after the end date.
- * I understand that I, or my authorized representative, is entitled to receive a copy of this authorization form.
- * I certify that I am an admitted [ABC University] student as of the date of this application.

SIGNATURE OF APPLICANT

DATE OF APPLICATION – Month, Day, Year



Nationwide Life Insurance Company

Home Office: Columbus, Ohio

Fraud Warnings

(New York) Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

(California) For your protection California law requires the following to appear on this form. Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

(Florida) Any person who knowingly and with intent to injure, defraud, or deceive any insurance company files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

(Louisiana) It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

(Missouri) An insurance company or its agent or representative may not ask an applicant or policyholder to divulge in a written application or otherwise whether an insurer has canceled or refused to renew or issue to the applicant or policyholder a policy of insurance. If a question(s) appears in this application, you should not renew it.

(Pennsylvania) Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

(Puerto Rico) Any person who, knowingly and with the intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine of no less than five thousand (5,000) dollars nor more than ten thousand (10,000) dollars, or imprisonment for a fixed term of three (3) years, or both penalties. If aggregated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a maximum of two (2) years.

(Washington) Any person who knowingly presents a false or fraudulent claim for payment of a loss or knowingly makes a false statement in an application for insurance may be guilty of a criminal offense under state law."

(All Other States) Any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and/or civil penalties.



On Your Side®

Nationwide Life Insurance Company

Home Office: Columbus, Ohio

BLANKET STUDENT ACCIDENT & SICKNESS POLICYHOLDER APPLICATION

Application is Hereby Made to

NATIONWIDE LIFE INSURANCE COMPANY

NAME OF SCHOOL	[University of USA]	DATE:	[September 1, 2007]
POLICYHOLDER:	[University of USA]	POLICY NUMBER:	[01KC-528000, 52800G]
MAILING ADDRESS:	[123 Castle Street Richmond, Virginia 00000]	EFFECTIVE DATE:	See Face Page
		TERMINATION DATE:	See Face Page

CLASSES OF PERSONS TO BE INSURED:

[All registered International student attending the [University of Virginia] are required to purchase the Plan and are enrolled at registration.]

[All other students registered for six or more undergraduate credit hours or three or more graduate credit hours and students participating in a co-op program or practice teaching are eligible and may enroll in the Plan.]

[Home study, correspondence, and television (TV) courses do not fulfill the Eligibility requirements that the Insured person actively attend classes. If the Company discovers the Eligibility requirements have not been met, its only obligation is to refund premium.]

[Eligible students who do enroll may also insure their Eligible Dependents as defined in the policy.]

Fraud Notice

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Signature of School Official _____

Title _____ Date _____

Please Print Name of Above Official _____

Signature of Agent _____ Date _____

Signature of Authorized Company Representative _____ Title _____ Date _____

Fraud Warnings

(New York) Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

(California) For your protection California law requires the following to appear on this form. Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

(Florida) Any person who knowingly and with intent to injure, defraud, or deceive any insurance company files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

(Louisiana) It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

(Missouri) An insurance company or its agent or representative may not ask an applicant or policyholder to divulge in a written application or otherwise whether an insurer has canceled or refused to renew or issue to the applicant or policyholder a policy of insurance. If a question(s) appears in this application, you should not renew it.

(Pennsylvania) Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

(Puerto Rico) Any person who, knowingly and with the intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine of no less than five thousand (5,000) dollars nor more than ten thousand (10,000) dollars, or imprisonment for a fixed term of three (3) years, or both penalties. If aggregated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a maximum of two (2) years.

(Washington) Any person who knowingly presents a false or fraudulent claim for payment of a loss or knowingly makes a false statement in an application for insurance may be guilty of a criminal offense under state law."

(All Other States) Any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and/or civil penalties.

CONVERSION PRIVILEGE RIDER

NATIONWIDE LIFE INSURANCE COMPANY Columbus, Ohio

Issues this rider to

THE INSURED REFERRED TO ON THE COVER PAGE OF THE POLICY TO WHICH
THIS RIDER IS ATTACHED AND MADE A PART THEREOF

The effective date of this rider is the effective date of the Policy to which this rider is attached.

The Policy is amended as described below. All other terms remain unchanged.

CONVERSION PRIVILEGE

We have contracted with another licensed insurer (hereafter called Conversion Carrier) to issue and administer the conversion coverage described in this section. You may contact Us to begin the application process.

You may be eligible for the health conversion coverage described below if Your Coverage under the this Policy ends because:

- (1) the Eligible Person is no longer an eligible student of the Policyholder;
- (2) the Eligible Person died;
- (3) Your Dependent status changed;

You must be insured under this Policy or any policy which it replaced for at least one year before You may apply for conversion coverage.

Benefits and premiums under conversion contracts may differ from Benefits and Premium under this Policy. No lapse in Coverage is permitted. The effective date of the conversion contract will be the day following the date Coverage under this Policy terminates, if within the 31 day conversion period You submit a completed application and pay the required premium to the Conversion Carrier.

If extended benefits are payable under this Policy, the amount payable under the conversion plan will be reduced. The total amount paid will not exceed the amount that would have been payable under this Policy.

You will receive written notice from Us or the Conversion Carrier about the conversion option. This notice will be mailed to Your address listed in the Policyholder's records. The Policyholder must notify Us or the Conversion Carrier of the event giving rise to the conversion option. You have 31 days from the date of the event to apply for a conversion contract and pay the initial premium.


If You do not receive written notice of the conversion option at least 15 days prior to the end of the 31 day conversion period, the conversion period will be extended. The extension period ends 15 days after notice is sent. The maximum extension period is 91 days after the date of the event giving rise to the conversion option. Your completed application and required premium must be received during the applicable extension period before Your conversion coverage will take effect.

No conversion contract will be issued if:

- (1) the Covered Person is eligible for similar benefits from any other source, including any other group benefit plan or Medicare;
- (2) Coverage was ended by Us for cause. Cause may include, but is not limited to:
 - (a) noncompliance with Our terms and conditions as determined by Us;
 - (b) nonpayment of Premium; or
 - (c) fraud;
- (3) Coverage under this Policy terminates because the entire Policy is terminated;
- (4) You have received maximum Benefits available under this Policy; or
- (5) total benefits provided by conversion coverage and any other health coverage would result in overinsurance.

The conversion coverage may be cancelled if certain events occur as described in the conversion policy.

NATIONWIDE LIFE INSURANCE COMPANY



President

INFERTILITY POLICY RIDER

NATIONWIDE LIFE INSURANCE COMPANY Columbus, Ohio

Issues this rider to

THE INSURED REFERRED TO ON THE COVER PAGE OF THE POLICY TO WHICH THIS
RIDER IS ATTACHED AND MADE A PART THEREOF

The effective date of this rider is the effective date of the certificate to which this rider is attached.

The Policy is amended as described below. All other terms remain unchanged.

Subject to the Benefits and Limitations in the Policy, this Rider provides an infertility benefit.

Infertility benefits limited to [\$1,000 - \$2,000] per benefit year.

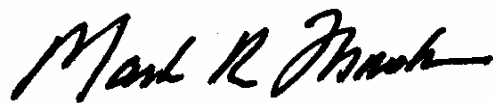
Infertility drugs limited to [\$500 - \$1, 000] per benefit year.

Infertility benefit includes the diagnosis and treatment of infertility. Services are limited to:

- Any costs associated with the collection, preparation or storage of sperm or ovum for artificial insemination (including donor fees)
- Artificial insemination
- Infertility drugs
- Hormone therapy or drugs
- In vitro fertilization
- Gamete Intrafallopian Transfer (GIFT)
- Zygote Intrafallopian Transfer (ZIFT)
- Embryo transplants
- Surgical reversal of voluntary sterilization

Excluded services include any claims associated with Surrogate parenting.

NATIONWIDE LIFE INSURANCE COMPANY



President

TREATMENT OF OBESITY RIDER

NATIONWIDE LIFE INSURANCE COMPANY Columbus, Ohio

Issues this rider to

THE INSURED REFERRED TO ON THE COVER PAGE OF THE POLICY TO WHICH THIS
RIDER IS ATTACHED AND MADE A PART THEREOF

The effective date of this rider is the effective date of the Policy to which this rider is attached.

The Policy is amended as described below. All other terms remain unchanged.

Subject to the Benefits and Limitations in the Policy, this Rider provides a benefit for the treatment of obesity as follows:

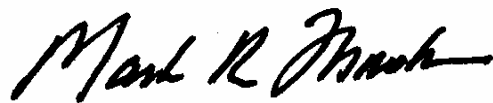
Services and associated expenses for the treatment of obesity and any resulting complications, consequences and after effects of such surgery and any other associated expenses, including, but not limited to:

- Gastric or intestinal bypasses;
- Gastric balloons;
- Stomach stapling;
- Wiring of the jaw;
- Panniculectomy;
- Appetite suppressants;

Surgery for removal of excess skin or fat is specifically excluded from coverage under the Policy and this Rider.

The maximum lifetime amount that will be payable under this benefit is [\$25,000, \$50,000, \$75,000].

NATIONWIDE LIFE INSURANCE COMPANY



President

ORGAN TRANSPLANT POLICY RIDER

**NATIONWIDE LIFE INSURANCE COMPANY
Columbus, Ohio**

Issues this rider to

THE INSURED REFERRED TO ON THE COVER PAGE OF THE POLICY TO WHICH THIS
RIDER IS ATTACHED AND MADE A PART THEREOF

The effective date of this rider is the effective date of the Policy to which this rider is attached.

The Policy is amended as described below. All other terms remain unchanged.

Subject to the Benefits and Limitations in the Policy, this Rider provides an organ transplant benefit.

Organ Transplant: The following transplants, including organ acquisitions, hospital services, related services and supplies which are determined to be Medically Necessary for the treatment of a Condition are covered: Solid organs, including but not limited to: autologous and allogenic bone marrow transplants, autologous and allogenic stem cell transplants. In addition, coverage is provided for anything caused by, contributed to, or resulting from an organ transplant, including complications thereof.

NATIONWIDE LIFE INSURANCE COMPANY

A handwritten signature in black ink, appearing to read "Mark R. Frank". The signature is fluid and cursive, with a long horizontal stroke at the end.

President

SPORTS ACCIDENT RIDER

**NATIONWIDE LIFE INSURANCE COMPANY
Columbus, Ohio**

Issues this rider to

THE INSURED REFERRED TO ON THE COVER PAGE OF THE POLICY TO WHICH THIS
RIDER IS ATTACHED AND MADE A PART THEREOF

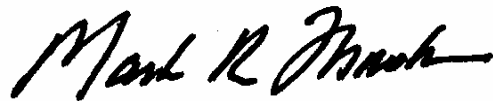
The effective date of this rider is the effective date of the Policy to which this rider is attached.

The Policy is amended as described below. All other terms remain unchanged.

Subject to the Benefits and Limitations in the Policy, this Rider provides benefits for injuries sustained while (a) participating in any [intramural], [intercollegiate], [professional], [semi-professional] or [club sport, contest, or competition]; (b) traveling to or from such sport, contest, or competition as a participant; or (c) while participating in any practice or conditioning program for such sport, contest, or competition;

The maximum benefit for under this rider is [[\$1000, \$2000] per injury] [\$25,000 lifetime].

NATIONWIDE LIFE INSURANCE COMPANY

A handwritten signature in black ink, appearing to read "Mark R. Throckmorton". The signature is fluid and cursive, with a long horizontal stroke at the end.

President

TRANSGENDER POLICY RIDER

NATIONWIDE LIFE INSURANCE COMPANY Columbus, Ohio

Issues this rider to

THE INSURED REFERRED TO ON THE COVER
PAGE OF THE POLICY TO WHICH THIS RIDER IS ATTACHED
AND MADE A PART THEREOF

The effective date of this rider is the effective date of the Policy.

The Policy is amended as described below. All other terms remain unchanged.

This rider provides a benefit for Transsexualism/Gender Identity Disorder as follows:

[Option 1: Subject to the benefits and limitations in the Policy, treatment is limited (up to the benefit maximum for each) to mental health counseling and hormone replacement therapy.

Gender reassignment is excluded.]

[Option 2:

Subject to the benefits and limitations in the Policy, treatment includes:

- Mental Health Counseling (subject to Mental Health Inpatient/Outpatient benefit limitations)
- Hormone replacement therapy (subject to the pharmacy benefit limitations)
- Gender reassignment surgery which is limited to the following surgeries at [\$25,000] dollars per benefit year:

Female to Male:

Mastectomy, Hysterectomy, Salpingo-oophorectomy, Vaginectomy, Metoidioplasty, Scrotoplasty, Urethroplasty, Placement of testicular prostheses, Phalloplasty; or

Male to Female:

Orchiectomy, Penectomy, Vaginoplasty, Clitoroplasty, Labiaplasty]

NATIONWIDE LIFE INSURANCE COMPANY



President

<i>SERFF Tracking Number:</i>	<i>NWLC-125633999</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Nationwide Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>39003</i>
<i>Company Tracking Number:</i>	<i>COLLEGE POLICY 2008</i>		
<i>TOI:</i>	<i>H04 Health - Blanket Accident/Sickness</i>	<i>Sub-TOI:</i>	<i>H04.001 Student</i>
<i>Product Name:</i>	<i>Blanket Student Accident and Sickness Policy</i>		
<i>Project Name/Number:</i>	<i>2008 College Filing/</i>		

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number: NWLC-125633999 State: Arkansas
Filing Company: Nationwide Life Insurance Company State Tracking Number: 39003
Company Tracking Number: COLLEGE POLICY 2008
TOI: H04 Health - Blanket Accident/Sickness Sub-TOI: H04.001 Student
Product Name: Blanket Student Accident and Sickness Policy
Project Name/Number: 2008 College Filing/

Supporting Document Schedules

Satisfied -Name: Certification/Notice	Review Status: Approved-Closed	05/16/2008
Comments:		
Attachments:		
Certification of Compliance.PDF		
Read Cert.pdf		
Satisfied -Name: Application	Review Status: Approved-Closed	05/16/2008
Comments:		
Application included under the Form Schedule tab.		
Satisfied -Name: EOVS	Review Status: Approved-Closed	05/16/2008
Comments:		
Attachment:		
College EOVS.pdf		

CERTIFICATION OF COMPLIANCE

Name and Address of Insurer:

Nationwide Life Insurance Company
Special Risks Underwriting
5525 Parkcenter Circle
Dublin, OH. 43017-3584
Mail Code: CO-03-30

Policy/Certificate Form Number(s):

NSHSAS 2000 AR	Policy
NSHSAS 2500 AR	Brochure
NSHSAS 2400 Transgender	Transgender Rider
NSHSAS 2400 Infertility	Infertility Rider
NSHSAS 2400 Organ Transplants	Organ Transplant Rider
NSHSAS 2400 Sports Accident	Sports Accident Rider
NSHSAS 2400 Obesity	Obesity Rider
NSHSAS 2400 Conversion	Conversion Rider
NSHSAS 2800	Enrollment Form
NSHSAS 2300	Application

I certify that, to the best of my knowledge and belief, the policy/certificate forms are in compliance with Arkansas Rule/Regulation 19, Arkansas Rule/Regulation 49 and the Consumer Information Notice as outlined in ACA 23-79-138.



Bobby Handley
Assistant General Counsel

Date: May 14, 2008

CERTIFICATION OF COMPLIANCE WITH
INSURANCE POLICY SIMPLIFICATION REQUIREMENTS

Name and Address of Insurer:

Nationwide Life Insurance Company
Special Risks Underwriting
5525 Parkcenter Circle
Dublin, OH. 43017-3584
Mail Code: CO-03-30

Policy/Certificate Form Number(s):

NSHSAS 2000 AR	Blanket Student Accident and Sickness Policy
NSHSAS 2500 AR	Brochure
NSHSAS 2400	Blanket Student Accident and Sickness Transgender Rider
NSHSAS 2400	Blanket Student Accident and Sickness Infertility Rider
NSHSAS 2400	Blanket Student Accident and Sickness Organ Transplant Rider
NSHSAS 2400	Blanket Student Accident and Sickness Sports Accident Rider
NSHSAS 2400	Blanket Student Accident and Sickness Obesity Rider
NSHSAS 2800	Blanket Student Accident and Sickness Enrollment Form
NSHSAS 2300	Blanket Student Accident and Sickness Application Form

I certify that, to the best of my knowledge and belief, the policy/certificate forms are in compliance with the Flesch reading ease score and the other requirements set forth in the Insurance Policy Language Simplification Act of the State of Arkansas.



Tom DeNoma
Associate Vice President

Date: May 14, 2008

STATEMENT OF VARIABILITY
NATIONWIDE LIFE INSURANCE COMPANY
BLANKET STUDENT ACCIDENT AND SICKNESS POLICY
POLICY FORM NSHSAS 2000

Throughout the policy co-pays, co-insurance percentages, maximum benefit amounts, etc. are bracketed with amounts located within the brackets. These amounts are what will be used. Each school will choose the amount that they want.

All wording that is bracketed will either be in or out. No new wording will be added.

- The policy can be issued to undergraduate, graduate or international students.
- Policyholder Name -- Actual name of policyholder will be substituted.
- Policy Number -- Actual policy number will be substituted.
- Effective Date -- Actual effective date will be substituted.
- Termination Date -- Actual termination date will be substituted.
- If the policy is excess, the excess only language will be included.
- Table of contents. The table of contents will vary. Each school can choose difference benefits. Page numbers will also vary. Items will either be in or out. Nothing will be added.
- Schedule of Benefits. All bracketed items will either be in or out. No changes in verbiage will occur.
- Schedule of Benefits –
 - Lifetime Maximum Benefit, Policy Year Maximum Benefit, and Per Injury or Sickness Maximum Benefit. Only one will be chosen by each school. The amount will vary by school. It will range from \$10,000 to up to \$1 million.
 - Pre-notification Penalty and Pre-Certification Penalty. Only one will be chosen by each school.
 - Treatment for injury resulting from a motor vehicle will be chosen (or not) by each school.
 - Co-payments, In Network and Out of Network benefit levels- Schools will choose level of co-payments, coinsurance, deductible and maximum limit amounts.
 - The Student Health Services section of the Schedule is bracketed because not all schools have a health center. If there is no health

center, the only available options will be in-network and out-of-network.

- Individual sections of the schedule of benefits are bracketed. Each school will choose the benefits it wants to provide to the students. The benefits will either be in or out. No additional benefits will be added unless they are filed with the department of insurance.
- Accidental Death and Dismemberment Benefits will be included only if the school wants to provide this benefit.

- Page 31 -- Most Definitions are bracketed. They will be either in or out depending on the benefits chosen by each school. No additional definitions or changes in wording will occur.
- Page 42 – Eligibility – Number of days will be determined by each school.
- Page 42 -- Credit Hour Requirements – number of hours will be chosen by each school.
- Page 43 – Dependents Acquired After Effective Date – Will be in or out if dependents are included in the polic.
- Page 44 – Terminations – bracketed material will be in or out.
- Page 44 – Extension of Benefits. This section will either be in or out. Each school will decide.
- Page 45 – Continuation of Coverage. This section will either be in or out. Each school will decide.
- Page 45 – Reinstatement of Reservist After Release from Active Duty.
- Page 46 – Covered Services – Wellness Covered Services. Items 1 and 2. Either in or out. Each school will decide.
- Page 47 - Covered Services – Outpatient Covered Services. Either in or out. Each school will decide.
- Page 48 - Reproductive Covered Services. Items 2 and 3. Either in or out. Each school will decide.
- Page 48 - Mental Health/Substance Abuse for Severe Mental Illness and Serious Emotional Disturbance of a Child will be either in or out. Each school will decide.
- Page 48 - Out of network benefits for Inpatient mental health/substance abuse facility services subject to the per day maximum limit will be either in or out. Each school will decide.
- Page 49 – Urgent Care. Bracketed items will either be in or out. Each school will decide.

- Page 49 – Other Covered Services. Sections will either be in or out. Each school will decide.
- Page 54 – Prescription drugs. Sections will either be in or out. Each school will decide.
- Pages 38 to 39– Accident Death and Dismemberment Benefit. This entire section will either be in or out. Each school will decide.
- Page 59 – General Exclusions and Limitations. The bracketed exclusions will either be in or out. No additional exclusions will be added and no wording changes will be made.
- Page 63 – Pre-Existing Conditions Limitation. This section will either be in or out. Each school will decide.
- Page 64 – Pre-Certification Process. This section will either be in or out. Each school will decide.
- Page 65 – Pre-Admission Notification. This section will either be in or out. Each school will decide.
- Page 66 – Preferred Provider Benefit. This section will either be in or out. Each school will decide.
- Page 67 – Student Health Service Referral. This section will either be in or out. Not all schools have a student health center.
- Pages 68 – Coordination of Benefits. This section will either be in or out. Each school will decide.
- Page 71 – Claim Provisions. AD&D Provisions. Use will depend on whether or not there is an AD&D benefit.
- Page 72 – Medical Necessity and Medical Appropriateness Determination. This section will either be in or out. Each school will decide.
- Page 74 – Subrogation and Recovery Rights. This section will either be in or out. Each school will decide.
- Page 75 – Excess Provision. If the policy is excess, then this section will be included.
- Pages 77 – External Appeal Process. Number 2. This section will either be in or out. Each school will decide.
- Page 61– Important Notice. Contact Information could change.